INFORMED CONSENT FORM & TERMS FOR NUTRITION COUNSELING

I, _____ *(PLEASE PRINT NAME),* give consent to Complete Health of Lawrenceville to provide Nutrition Counseling to myself or the client for which I am legally responsible. The consult will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle. I acknowledge the purpose of nutritional counseling is to support wellness, a healthy attitude, lifestyle, and diet and that results are not guaranteed. I understand that Dr. Renee Robus is practicing nutrition counseling under her scope of practice as a licensed Doctor of Chiropractic. She will enhance my knowledge of health through food, dietary supplements, and eating behaviors.

While nutritional support can be an important compliment to my health and disease management, I understand these services are not a substitute for medical care. Additionally, I understand that any information provided is a recommendation for improving health and not a prescription. Nutritional counseling is an important compliment to health and disease management, but is not a substitute for medical diagnosis, treatment, or the care of a medical physician. Additionally, I promise to provide a complete and accurate account of any medical conditions that I may have and any medications that I am taking.

Methods of nutrition evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals. Medical records and personal information and history divulged in session to Complete Health of Lawrenceville will be kept confidential unless I consent to sharing my medical information.

I hereby release and discharge, indemnify, and hold harmless Complete Health of Lawrenceville, their officers, agents, employees, and persons acting on their behalf, from all claims, demands, costs and expenses, and causes of action, either in law or equity arising out of or in any way connected to services I receive from Complete Health of Lawrenceville. I have read this consent form and terms contained herein carefully. I understand the terms of this form fully and voluntarily agree to be bound by them.

_____ _____

PATIENT SIGNATURE DATE

COMPLETE HEALTH
OF LAWRENCEVILLE

NUTRITION COUNSELING FINANCIAL POLICY

Thank you for choosing Complete Health of Lawrenceville has a part of your health care team. The following is a statement of our Nutrition Counseling Financial Policy, which we require you to read and sign prior to treatment.

By initialing and signing this form in the designated spots below, I acknowledge and accept the following:

Please Initial

_____ I understand that I have the option of paying per visit or paying in full for the entire six-month program. If paying per visit, the initial consult/evaluation is **$200.00** and all subsequent follow-up appointments are **$100.00** per visit. I understand that all services are to be paid in full at the time of my visit. If committing to the six-month program (which includes the initial consult/evaluation and 9 follow-up sessions), the total amount of **$825.00** is due at my first visit.

_____ **I understand that Complete Health of Lawrenceville does not accept assignment of insurance benefits for nutritional based services.** If needed, I can request a statement printout to submit to my insurance or HSA company. I recognize that treatment codes used for billing are non-traditional and may not be accepted by my insurance or HSA company, despite having nutrition-based benefits as part of my policy.

_____ If my counseling includes the purchase of supplements, I understand that payment is required before the supplements are ordered. Likewise, a shipping fee of **$7.00** will apply per order. These supplements are non-refundable, even if they are unopened. Complete Health does not allow any returns on supplements as we are unable to control the temperature of these products once they leave the office.

_____ **I understand that I am required to give Complete Health of Lawrenceville 24 hours notice if I need to cancel or reschedule my appointment.** If I cancel within 24 hours or NO SHOW for my scheduled appointment time, I accept that I may be charged a fee of **$40.00**.

_____ I understand that my payments, whether towards individual sessions or the 6-month program, are **non-refundable** and **non-transferrable**. These payment(s) will apply only to Nutrition counseling and cannot be used for other Complete Health of Lawrenceville services, copays, or towards a deductible. Likewise, I acknowledge that these payments can only be used for myself (listed below) and cannot be transferred to another patient.

_____ _____

PATIENT NAME DATE

_____

PATIENT SIGNATURE

COMPLETE HEALTH
OF LAWRENCEVILLE