



Informed Consent and Financial Responsibility Form

PLEASE READ CAREFULLY PRIOR TO SIGNING:

I understand that the Dietitians working with Nutrition Matters, LLC (herein referred to as "the RDs"), are Registered Dietitians. The RD's are not physicians trained to diagnose and treat medical problems. I give permission to the RDs to communicate with my physician in order to coordinate nutrition advice with my medical history. I agree to keep the RDs informed of any changes to my medical condition.

I also understand that the success I achieve in this program strongly depends on my ability to make permanent changes in my eating and exercise behavior. I agree to follow-up with the RDs for scheduled nutrition counseling sessions. I am aware that the RDs make no claims or warranties regarding the results I should obtain under their direction.

Successful medical nutrition therapy involves behavioral change. This change requires that I keep my scheduled appointments. If I miss any pre-paid sessions without prior arrangements, it will be counted as a completed session as this time could have been used for other patients and encourages my compliance with this program. No refunds or exchanges will be given at any time before and/or during any consultations or package programs, as outlined in the Cancellation Policy. If any of my appointments have prior authorization by my insurance company, I authorize payment by my insurance company to Nutrition Matters, LLC. Any balances not approved or covered by my insurance company are my financial responsibility.

Nutrition Matters, LLC maintains confidentiality of all patient issues unless given permission to communicate with your health care provider, by your signature below or if the RDs feel your issues present a life-threatening situation.

Your signature indicates your understanding and acceptance of above policy and that you may request a copy of this agreement at your request anytime.

Signature of patient or legal guardian

Date

Print patient name

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