

**CONSENT TO TREAT**

I, the undersigned, a client of this office, hereby authorize Nuview Nutrition LLC to administer treatment as necessary, if needed, within the lawful scope of Nutrition therapy. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Consent for a minor (if applicable): I, the undersigned, hereby authorize Nuview Nutrition LLC to administer treatment as necessary, if needed, within the lawful scope of Nutrition therapy to My child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

I have received and reviewed the “Notice of Privacy Practices for Protected Health Information,” which describes how my medical information may be used and disclosed, and how I can get access to this information. A copy of this document is available to me at any time.

The above information is true and accurate to the best of my knowledge, and I understand and agree to the statements above.

Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION TO USE TESTIMONIALS**

I, the undersigned, a client of Nuview Nutrition LLC authorize and give consent to use my experience with Nuview Nutrition as a testimonial for marketing purposes, on the website, in printed materials, and in conversation without the disclosure of my name. I give consent to utilize my initials, City and State on my testimonial statement.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NO SHOW FEES**

I, the undersigned, understand that my failure to show for the first appointment without contacting the office beforehand will result in Nuview Nutrition LLC holding my $280 deposit. I also understand that my failure to show/give 24-hour notice for any following appointments will result in a $45 NO SHOW FEE, owed to Nuview Nutrition LLC and will be charged immediately to my card on file.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAPERWORK DUE DATE AND RESCHEDULING**

I, the undersigned, understand that my inability to return my completed paperwork **by/before the date one week prior** to my scheduled 2-hour intake appointment (or the date declared to me by the office staff) may result in my first intake appointment needing to be rescheduled if the nutritionist does not have time to create my plan due to late paperwork. If I find that I cannot return my paperwork by the declared date, I will contact Nuview Nutrition ASAP to ask for extended time if possible, or to reschedule the appointment.

Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PACKAGE EXPIRATION ACKNOWLEDGEMENT**

I, the undersigned, understand that my package does expire; any unused visits from this package will expire after exactly **one year** from my first appointment.

Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN AND LET THEM KNOW THAT WE ARE WORKING WITH YOU? IF SO, PLEASE FILL OUT THEIR CONTACT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_