

Informed Consent for Nutrition Counselling Services

In order to clarify Heather Neely-Billing's position as a health care practitioner, and the mutual responsibility you have in your health care, please sign this statement of acknowledgement.

I, _____ (PRINT NAME),

AS "THE CLIENT", HEREBY ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

1. The purpose of nutrition counselling is to improve overall health, vitality and well-being of the body through nutritional education and the use of natural foods and non-medicinal nutritional supplements. Heather Neely-Billings, as my Nutritionist, **does not diagnose diseases, disorders or conditions.**
2. That Heather Neely-Billings, as my Nutritionist, is not a *licensed Dietitian, Naturopath or physician.*
3. As part of Heather Neely-Billings Nutrition Counselling services, I may be asked to provide information concerning my *physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet.* This information is collected to enable Heather Neely-Billings to **(i) assess my knowledge of nutrition, (ii) educate me about the benefits of sound nutritional practices, and (iii) recommend dietary changes to improve my general health, vitality and overall well-being.** Mouthfull Nutrition will hold this information in confidence and will not release or disclose this information to any other person, without my prior consent, except as required by applicable law.
4. If Heather Neely-Billings, suspects the existence of a disease, disorder or condition, I will be informed of this suspicion. However, I acknowledge this is not a diagnosis or conclusion about the state of my health and that I am directed to promptly consult a licensed physician or Naturopath about any suspected problems.
5. Dietary changes and nutritional supplements suggested by Heather Neely-Billings are intended to improve the general health, vitality and well-being of my body and are not recommended for the purposes of treating diseases, disorders or conditions. **I am not to alter or discontinue treatments prescribed by a licensed physician, Naturopath or other licensed health professional without consulting the individual who prescribed the treatment.**

continued ...

6. In providing nutrition counselling services to me, Heather Neely-Billings is relying upon the truth, accuracy and completeness of all the information I have provided to them. Any recommendations I follow for changes in diet, including the use of nutritional supplements, are entirely my responsibility.

7. There are some slight health risks Nutritional Counselling. These include but are not limited to:

- **Aggravation of pre-existing symptoms;**
- **Allergic reactions to supplements or foods**

I understand that results are not guaranteed. I do not expect Heather Neely-Billings to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Nutritional Counselling Services I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Insurance Coverage: Many health insurance plans cover Nutrition services under “Nutritional Counselling.” Contact your provider for details.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that Heather Neely-Billings may discuss my case with other healthcare providers. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

In consideration of my participation in Nutrition Counselling Services, I hereby accept all risk to my health that may result from such participation and I hereby release Heather Neely-Billings, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, that may result from or occur as a result in my participation in the Nutrition Counselling Services, whether caused by negligence or otherwise.

CLIENT NAME (Please print)

CLIENT (or Legal Guardian) **SIGNATURE**

DATE