

Nutrition Solutions

12900 NE 180th Street • Suite 100 • Bothell, WA 98011 • (425) 385-2809

Consent for Treatment

I, the undersigned, voluntarily consent to receive nutrition counseling services from Debie McSperitt RD, CD at the specified fee and payment schedule. I have read and understood all of the information provided in the disclosure statement. I understand that as with all medical treatment, there is no guarantee that this treatment will offer a complete resolution to any or all conditions that I may have. I understand that Nutrition Solutions will keep a record of the healthcare services provided to me. This record will be confidential and will not be released to others unless so directed by myself, my legal representative, or unless required by law.

This consent shall be in effect for the duration of treatment.

Patient's Name
(Please Print)

Signature

Date

Consent for Treatment for a Minor or Dependent Adult

If the patient is a minor, a dependent adult, or for whatever reason not responsible for payment of the services rendered, the person signing this contract accepts full responsibility for payment of the professional fees. This person agrees to all of the contract terms as specified for the professional services rendered to the patient.

Name of Person Responsible for Payment
(Please Print)

Signature

Date