**Client Waiver and Acknowledgement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby grant permission for Rachel Freeman, MSc, RD to request information from me that is relevant to my (or my child’s) nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence. I further acknowledge the information provided to me by Rachel Freeman is designed to meet my (or my child’s) personal dietary needs. It is NOT suitable for any other individuals and will not be transferred, copied or sold to another person.

In order to benefit from treatment recommended by Rachel Freeman, I realize that it is important for me to inform either my physician or Rachel Freeman of any changes I make in the application of my (or my child’s) diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/or Rachel Freeman. I will not hold my physician or Rachel Freeman responsible for any complications that result from my failure to comply with either of the above.

I agree to have my Registered Dietitian keep records of our visits and to file these in a secure place. I agree to allow my Registered Dietitian contact other health professionals including my (or my child’s) physician if needed to benefit in my (or my child’s) care and to share my (or my child’s) personal information if needed for concerns or for continuity of care. This may be accomplished by letter, phone, fax or email.

**Cancellation policy:** Twenty-four (24) hour notice is needed to cancel/reschedule your appointment. This allows our office to seek a replacement. If 24 hrs notice is not provided, a fee of $50 will be charged. Thank you for your cooperation and understanding.

All professional services are charged directly to the client.

*\*\*Services are to be paid by* ***cheque, cash, or e-transfer*** *at each visit.\*\**

We will prepare any necessary forms or reports to help you collect your benefits from insurance companies or employee assistant programs. Please contact your employer or insurance company prior to your first visit to clarify your coverage.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dietitian 4 Health