**Client Waiver and Acknowledgement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby grant permission for Laura Balla, RD to correspond with my physician (s) to obtain information relevant to my 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 Laura Balla is designed to meet my 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 prescribed by Laura Balla, I realize that it is important for me to inform either my physician or Laura Balla of any changes I make in the application of my 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 Laura Balla. I will not hold my physician or Laura Balla responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have my Registered Dietitian keep records of our visits and to file these in a secure place. I have agreed to have the Registered Dietitian contact other health professionals to benefit in my care and to share my personal information. This may 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 $25 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 or cash 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 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietitian 4 Health