Informed Consent

Clinical Nutrition Program

Please read, fill in blanks, sign , then USPS mail Original to A.C.N. within 24 hours.

An **Informed Consent** communicates policies and procedures of ***Advanced Clinical Nutrition (A.C.N.)***, so we may provide our services with clarity and your "consent." This Informed Consent is about your Clinical Nutrition Program.

1. I understand that Services are provided for Clinical Nutrition Analysis of Laboratory Testing and other Nutritional Assessment and Evaluations to design a therapeutic supplement and dietary plan, in addition to providing lifestyle education, for the purpose of improving my health, and not for the diagnosis, treatment or prescription for any medical symptom, disease, disorder or condition. Therefore, I understand that it is my responsibility to seek medical attention if I suspect or have a disease, disorder or condition. Please Initial Here: _____
2. Because the lifespan of the red blood cells is three months, I understand that it may take at least three months to replace nutrient-depleted, toxic red blood cells with healthy new cells. Consequently, I understand that this is required before my body can begin healing the cells of my tissue, organs, glands and physical structure. Therefore, I agree to give my Clinical Nutrition Program **at least** three months before I evaluate its effectiveness.
3. I understand that though it takes three months for my body to begin healing at a cellular level, I may experience improvement in my nutritional symptoms as early as three days to six weeks after beginning my Clinical Nutrition Program. Why? Because as my body becomes more nourished and less toxic, my biochemistry starts to return to a state of ease and symptoms begin to leave. Disease is the state of dis-ease in the body.
4. I understand that other factors, not related to nutritional biochemistry, such as lifestyle behaviors, medications, stress, exposures, etc., can interfere with the effectiveness of my clinical nutrition health improvement program. Therefore, I acknowledge that there is no guarantee regarding the success of my program and I hold Dr. Smith, ***Advanced Clinical Nutrition***, its staff and affiliates, blameless in regards to my clinical nutrition program. Initials: _____
5. I understand that the dispensing of therapeutic supplements requires a clinical nutrition analysis of the laboratory testing of my biochemistry (blood, urine, hair, saliva, and stool) and/or other nutritional evaluations and assessments. Therefore, I agree to obtain timely retesting of lab tests and evaluations. I understand that the first retesting and reevaluation is required in the fourth month, after starting my clinical nutrition program due to the lifespan of the red blood cells, and then at subsequent intervals as determined by the updated test results. Upon receipt of updated test results, Dr. Smith will provide date of next testing/evaluations in the **"Specimen Collection"** box at the top of my written **"Therapeutic Supplement Program of Care (POC),"** so I have time to prepare financially, if necessary. Please Initial Here: _____
6. I understand that the dispensing of therapeutic supplements also requires monitoring through **Progress Reporting** consultations. Furthermore, I understand that monitoring will be required first on a monthly basis and in time, on a periodic basis. Its frequency is determined by Dr. Smith in accordance to the specific criteria of my adherence to program instructions, consistency in making dietary and lifestyle changes, increased education, clinical improvement and standard of health.
7. I understand that unsupervised, unapproved, arbitrary changes to my program can result in sabotaging my healing progress. Therefore, I agree to adhere to my program instructions as directed without making any arbitrary changes. Should I desire to change any part or my entire program for any reason, I agree to first consult with Dr. Smith and any decision to change my program will result from mutual consent of Dr. Smith & me.

My signature below acknowledges that I read, understood, and agree to adhere to the policies on the "Informed Consent-Clinical Nutrition Program" and I am retaining the clinical nutrition ministry services of ***Advanced Clinical Nutrition (A.C.N.).*** I agree to re-read all policy documents for answers before contacting A.C.N., thus limiting direct questions to rulings on topics not included in their written policies. I understand that lack of adherence to policies listed in #19 on the "Informed Consent – Business Policies" (Page 3) is subject to termination of services and all policies are upheld without exception.

DATE:_____CLIENT SIGNATURE:_____ BIRTHDATE:_____

(If client is a minor, sign as follows: Sign Child's Name BY Parent or Legal Guardian's Name.)

PRINT FULL NAME:_____DAY PHONE: _____

(No P.O. Boxes)

HOME ADDRESS:_____CITY/STATE_____ZIPCODE_____