Informed Consent

Business Policies

Please read, fill in blanks, and sign all three pages, then USPS mail Originals 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 our Business Policies, which are also established to communicate both our and the client's responsibilities and procedures, so we may maintain a healthy working relationship and provide timely and efficient services. Therefore,

1. The term "products" represents any tangible item for sale, whether it is a book, personal care product, appliance, health equipment, therapeutic or maintenance supplement, lab report, article, e-book, etc.

2. Payment may be made by Visa, MasterCard or Discover cards only (credit, debit, check card or travel cards). Clients are sent an email receipt at time of payment through Authorize.Net.

3. Payment of services and products are pre-paid, such as Lab Requisitions; Lab Kits; Analysis Fees; Nutritional On-site Tests, Exams and Evaluations; Questionnaires for Evaluations; Books; PEP Articles; e-Books; therapeutic and maintenance supplements; personal care, household or other products; appliances, health equipment, and/or Special and Back Orders. No billing or monthly payment plans provided. Paid Invoices accompany products and Lab Kits. Please Initial Here: _____

4. Payment of consultations is due at the conclusion of the appointment, once total consultation time has been established. Consultations may also be pre-paid. However, if consultation time extends beyond amount pre-paid, payment is due for the balance when appointment has concluded. For example, when a Report of Findings Consultation exceeds the 15-minute consultation included in the Analysis Fee for some Lab Tests and Kits. Please Initial Here: _____

5. Clients receive an emailed receipt from our card processing company at the moment an invoice is paid with the Invoice Number on it for products and services paid. The Card Transaction Number and Authorization Code on this receipt is applied to paid Invoice, which accompany products and/or Lab Kits shipped. Paid Invoices for consultations are emailed 24-72 hours after appointments.

6. A.C.N. has a right to charge a fee for any payment that results in a card chargeback, stop payment, insufficient funds or other purpose, in addition to administrative or processing fees. Initial : _____

7. Client documents, such as completed A.C.N. Health, Symptom & History Questionnaires & Forms, medical or other documents may be sent to A.C.N. by fax, U.S. mail or email, except Informed Consents.

My signature below acknowledges that I read, understood, and agree to adhere to the policies on the "Informed Consent – Business Policies" (Page 1 of 3) and I am retaining the clinical nutrition ministry services of ***Advanced Clinical Nutrition (A.C.N.).*** I agree to re-read all policy documents thus limiting direct policy questions to rulings not included in their written policies. I understand that lack of adherence to A.C.N. policies 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: _____

CARD BILLING ADDRESS: _____CITY/STATE_____ZIPCODE_____

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8. Nutritional Evaluations and/or Laboratory Reports cannot be released to client until their A.C.N.-related questionnaire(s), such as the Health Appraisal Questionnaire (HAC), have been received and completed accurately. Please Initial Here: _____

9. It is the client's responsibility to add the scores for totals, sub-totals and grand totals on all questionnaires submitted for evaluation. Otherwise, a fee of $1/minute will be charged to add the scores for the client. Please Initial Here: _____

10. Lab Requisitions, Lab Kits, Analysis Fees, Evaluation Questionnaire Fees, pre-paid Consultations, Books, Clinically-formulated, therapeutic/maintenance supplements and/or products affected by temperatures, **cannot be returned or refunded**. No exceptions. Please Initial Here: _____

11. A "returnable" product is any product that is not subject to temperatures and is not listed in #10 above. Returns must be approved through an Administrative Telephone Consultation with Dr. Smith. Dr. Smith will also designate the postal carrier by which approved products may be returned, which depends upon the type of products being returned. Please initial Here: _____

12. Approved returnable products must be in good condition (e.g., seal intact, not damaged) and returned through the designated postal carrier within 14 days of purchase date to receive credit refund or return is denied. Please Initial Here: _____

13. Approved returnable products will incur a $10 or 20% of payment (whichever is greater) Refund, Return Processing or Restocking Fee, whichever is applicable; only Credit Refunds are provided and credit will be applied to the client's next invoice . Please Initial Here: _____

14. Postal Packages returned unopened or an unapproved return of any product(s) are denied. Returnable products need an administrative consultation with Dr. Smith first to approve return. Please Initial Here:____

15. Products are considered received undamaged and complete, if client has not communicated with A.C.N. within 24 hours from date received. If client will be out of town on receive date, client is responsible to make arrangement for a different receive date. Please Initial Here: _____

16. Changes or cancelation of supplement shipments are required in writing and cancellation of therapeutic supplements, along with a current inventory of my on-hand supply, is subject to approval by Dr. Smith to avoid inadvertently sabotaging my healing progress or accidentally closing therapy. Shipment cancellation notices received after the current Column #1 Date on the Auto-Ship Schedule apply to next upcoming Column #1 Date; and client is responsible for payment of shipment currently in process. Please Initial Here: _____

17. I acknowledge that providing an inventory of my **Program of Care (POC)** supplements is optional; however, if no inventory of supplements is provided on the **Column #1 Date of the Auto-Ship Schedule**, I acknowledge that I will receive a sufficient supply of supplements/products to last until I receive the next month's shipment to guarantee that I do not run out of any supplements prematurely. Please Initial Here: _____

My signature below acknowledges that I read, understood, and agree to adhere to the policies on the "Informed Consent – Business Policies" (Page 2 of 3) 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 policy questions to rulings not included in their written policies. I understand that lack of adherence to A.C.N. policies is subject to termination of services and all policies are upheld without exception.

DATE:_____CLIENT SIGNATURE:_____PRINT FULL NAME:_____
(If client is a minor, sign as follows: Sign Child's Name BY Parent or Legal Guardian's Name.)

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18. At least 48-hour notice to reschedule or cancel appointment required to avoid a charge of 50% of the pre-scheduled appointment fee. Reminder First Time; Reoccurrence Policy upheld. Initial: _____

19. Though we endeavor to provide advanced notice regarding price changes. Should prices change without notice, current prices are invoiced.

20. I acknowledge that to help Dr. Smith assist others in understanding the healing potential that is possible through clinical nutrition therapy, my case history and success stories may be shared with others and to protect my privacy and assure confidentiality, my name is not shared. Initial: _____

21. I understand that all Policy Documents are titled as "Guidelines, Policies and/or Procedures," and I have access to them on A.C.N.'s Client website. I understand that only the **Card Payment Authorization (CPA) Form, informed Consent-Clinical Nutrition Program and Informed Consent – Business Policies (ICs)** require my initials, signature on each page, and to be returned through the mail prior to receiving services beyond the Initial Telephone Consultation, Lab Tests and HAC Report, and I may periodically be required to initial/sign their updates. I am responsible to stay current and adhere to all policies, whether I have taken time to read them or not. Initial Here: _____

22. I understand that my email will be listed in the **Client Exclusive Emailing List** and I may unsubscribe at any time; however, doing this will cause me to miss Client Announcements, Health Alerts and FREE clinical education that relates to the my health now and in the future. Initial: _____

23. I understand that there is a right (respectable and honorable) way to start and receive Clinical Nutrition Therapy, and therefore, there is a right way to close Clinical Nutrition Therapy. Therefore, Therapy Closure Procedures are initiated when my tests and evaluations indicate that I am in optimal nutritional ranges and therefore no longer require Clinical Nutrition Therapy OR if I desire to close therapy prematurely.

    To close therapy in good standing with your company means I have completed the following Therapy Closure Procedures 1) provided my intentions in writing (providing a reason is appreciated also), if I initiated closure, 2) accurately completed and submitted an updated HAC Questionnaire and c) completed a Therapy Closure Telephone Consultation with Dr. Smith to be informed of:

    a. How to wean off therapeutic supplements to avoid upsetting my biochemistry,
    b. What is required to help me maintain the health improvement I have attained and to support any acquired or inherent biological or biochemical weaknesses.
    c. What to expect physically when supplement program is discontinued prematurely, such as potential resurfacing of symptoms in areas of my body that did not receive optimal healing due to discontinuing therapy prematurely, if applicable. Please Initial Here for Item #23 a.b.c.: _____

My signature below acknowledges that I read, understood, and agree to adhere to the policies on the "Informed Consent – Business Policies" (Page 3 of 3) 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 policy questions to rulings not included in their written policies. I understand that lack of adherence to A.C.N. policies is subject to termination of services and all policies are upheld without exception.

DATE:_____CLIENT SIGNATURE:_____PRINT FULL NAME:_____
(If client is a minor, sign as follows: Sign Child's Name BY Parent or Legal Guardian's Name.)