

## Informed Consent for Medical Nutrition Therapy

I hereby give consent to Shelby Erin Slenkamp, MS, RDN, CD to provide Nutrition Counseling to myself or the Patient for which I am legally responsible. The consultation will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle. The Patient acknowledges that the Patient takes full responsibility for the Patient's life and well-being, as well as the lives and well-being of the Patient's family and children (where applicable), and all decisions made during and after the duration of the Patient's nutrition and wellness coaching sessions. The Patient expressly assumes the risks of nutrition and wellness coaching sessions, including the risks of trying new foods, and the risks inherent in making lifestyle changes.

I understand that Shelby Slenkamp is a Registered Dietitian and not a medical physician. Thus, they will not diagnose medical conditions, but will provide nutritional support, nutrition education, and lifestyle guidance for an already diagnosed condition or set of symptoms. While nutritional support is an important complement to my health and disease management, I understand these services are not a substitute for other medical care. If the Patient is under the care of a healthcare professional or currently uses prescription medications, the Patient should discuss any dietary changes or potential dietary supplement use with his or her primary care physician, and should not discontinue any prescription medications without first consulting his or her primary care physician. Methods of nutrition evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, to help reduce symptoms, and to monitor my progress in achieving my goals.

Medical records and personal information and history divulged in session to the dietitian will be kept confidential, unless I consent to sharing my medical information. I hereby release and discharge, indemnify, and hold harmless KOKUA Lifestyle and Nutrition, their officers, agents, employees, and persons acting on their behalf, from all claims, demands, costs and expenses, and causes of action, either in law or equity arising out of or in any way connected to services I receive from Shelby Erin Slenkamp, MS, RDN, CD. \*Payments are due at the time of service and there are no refunds for payments made to KOKUA Lifestyle and Nutrition.

I have read this consent form and terms contained herein carefully. I understand the terms of this form fully and voluntarily agree to be bound by them.

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Patient or Legal Guardian's Signature

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Date

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Patient of Legal Guardian Printed Name