TREATMENT CONSENT FORM

In order to receive services, I acknowledge, understand, and consent to Registered Health Professionals of FOKUS health **(Hereby** "**Registered Staff")** 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 Registered Staff of FOKUS, 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 the treatment prescribed by Registered Staff, I realize that it is important for me to inform either my physician or Registered Staff of any changes I make in the application of my diet. I also understand it is my duty to report, provide, and disclose the most accurate health and medical information to Registered Staff, for them to provide any dietary recommendations or advice. 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 Registered Staff.

I will not hold my physician or Registered Staff 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 and appropriate place.

I agree to have the Registered Staff contact other Health Care Professionals involved in my care to benefit in my care and to share my personal information. This may be accomplished by letter, phone, fax, or email.

CANCELLATION POLICY:

Twenty-four (24) hours notice is needed to cancel/reschedule your appointment. This allows our office to seek a replacement. If 24 hours notice is not provided, a fee of $50.00 will be charged to you. Thank you for your cooperation and understanding.

_____	_____	_____
Name	Signature	Date