Diet Mentor
Weight Loss Done Right!

# Health Profile

Initial Consultation Date/Time:_____

The purpose of the health profile is not to establish a diagnosis but rather to determine your health status to guide your weight loss.

***We highly recommend you consult with your physician prior to starting this or any weight loss plan.***

## Legend (For Office Use)

**NPA = Needs Physician Approval**

## Overall (please print clearly)

First Name: _____ Last name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ E-mail: _____

Date of birth: _____ Age: _____ Profession: _____

What is your marital status?: ☐ Single ☐ Married ☐ Widow ☐ Divorce ☐ Other _____

How many children do you have_____ What are their ages?: _____

Who does most of the cooking at home?: _____

On average, how many hours do you sleep per night? _____

**Referral Source (How did you hear about us?):**_____

Current Weight: _____ Weight 1 year ago: _____ Minimum adult weight: _____ At age: _____

Do you exercise: ☐ Yes ☐ No If yes, what kind? _____

How often do you exercise? ☐ Daily ☐ Weekly ☐ Other _____

Have you ever been on a diet before?: ☐ Yes ☐ No
***If yes**, specify all diet(s) and why you think they did not work for you (i.e. too rigid, too much cooking, etc.)*

_____

**On a scale of 1 to 10, circle how important is it for you to lose weight and get healthy?**

Least important **1 2 3 4 5 6 7 8 9 10** Very Important

**Why do you want to lose weight?** _____

## FOR CLINIC USE ONLY:

| | |
|---|---|
| **START WEIGHT:** | **GOAL WEIGHT:** |
| **HEIGHT:** | **GOAL BMI:** |
| **DIET START DATE:** | **GOAL DATE:** **@** **/week** |
| **3-DAY F/U DATE:** | **PROGRAM:** KETO ☐ ALTERNATIVE ☐ |
| **PHYSICIAN CONSENT REQUIRED:** **YES** **NO** | **DATE PHYSICIAN CONSENT FAXED:** |
| **PERCENTAGES:** **10--** **20--** **30--** **40--** **50--** | |

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## PHYSICIANS: Reviewed: ☐

**Who is your Primary Care Physician:** _____

**Address:** _____

Please list any other physicians who treat you and their specialty:

Physician name: _____ Specialty: _____

Physician name: _____ Specialty: _____

Physician name: _____ Specialty: _____

## DIABETES: ☐ N/A Reviewed: ☐

Do you have diabetes: ☐ Yes ☐ No ***If no, please skip to next section***

If yes, which type: ☐ Type 1—Insulin dependent (insulin injections only)—**ALTERNATIVE PROTOCOL ONLY**

☐ Type 2—Insulin dependent (diabetic pills, and/or insulin injections)

Is your blood sugar monitored? ☐ Yes ☐ No If yes, how often?: _____

If so, by whom?: ☐ Myself ☐ Physician ☐ Other _____

Do you tend to be hypoglycemic?: ☐ Yes ☐ No ***If yes, please inquire about our alternative protocol.***

***NOTE: If you are currently on Sodium-Glucose Co-Transporter inhibitor medication (SGLT-2), which include Ebymect, Edistride, Forxiga, Invokana, Jardiance, Synjardy, Vokanamet and Xigduo--*****ALTERNATIVE PROTOCOL ONLY**

## CARDIOVASCULAR FUNCTION: ☐ N/A Reviewed: ☐

Do you or have you had any of the following conditions:

☐ Arrythmia **(NPA)**
☐ Blood clot **(NPA)**
☐ Coronary artery disease **(NPA)**
☐ Heart attack **(NPC)—*Must be 6 months post***
☐ Heart valve problem **(NPA)**
☐ Heart valve replacement **(NPA)**
☐ Hyperlipidemia (high cholesterol/triglycerides)
☐ Hyperkalemia (high potassium) **(NPA)**
☐ Hypokalemia (low potassium) **(NPA)**
☐ Hypertension (high blood pressure) **(NPA)**
☐ Pulmonary embolism **(NPA)**
☐ Stroke or transient ischemic attack **(NPA)**
☐ Congestive heart failure **(NPA)**
☐ Please select one (if applicable)
☐ History of congestive heart failure
☐ Current congestive heart failure

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

Have you ever had any type of heart surgery? ☐ Yes ☐ No

If yes, what type and when?: _____

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## KIDNEY FUNCTION: ☐ N/A Reviewed: ☐

Have you had any of the following conditions:

☐ Kidney disease **(NPA)**

☐ Kidney transplant **(NPA)**

☐ Kidney stones—***Must drink 80-100oz water daily***

☐ Do you presently or have you ever had gout? ☐ Yes ☐ No If yes, since when?: _____

If yes, what medication has been prescribed?: _____

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

## LIVER FUNCTION: ☐ N/A Reviewed: ☐

Have you ever had any liver conditions?: ☐ Yes ☐ No

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

## COLON FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Constipation
☐ Crohn's disease
☐ Diarrhea
☐ Diverticulitis
☐ Irritable bowel syndrome
☐ Ulcerative colitis

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

## DIGESTIVE FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Acid reflux
☐ Celiac disease
☐ Gastric ulcer **(NPA)--If yes, is your ulcer healed?** ☐ Yes ☐ ***No—If no, cannot do this program***
☐ Gluten intolerance
☐ Heartburn
☐ History of bariatric surgery **(NPA)**
If yes, date and type of surgery and current status: _____

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

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## OVARIAN/BREAST FUNCTION: ☐ N/A Reviewed: ☐

Do you currently have any of the following conditions?:

☐ Amenorrhea ☐ Irregular periods

☐ Fibrocystic breasts ☐ Menopause

☐ Heavy periods ☐ Painful periods

☐ Hysterectomy ☐ Uterine fibroma

Date of last menstrual cycle: _____

Are you taking or on any type of contraceptive birth control? ☐ Yes ☐ No

***IF YES, IMPORTANT--Changes in weight and/or estrogen levels may render birth control methods less effective and could result in pregnancy. Please discuss with your gynecologist a back-up or barrier birth-control method.***

Are you pregnant? ☐ Yes ☐ No ***If yes--CANNOT do program***

Are you breastfeeding ☐ Yes ☐ No ***If yes--CANNOT do program***

## ENDOCRINE FUNCTION: ☐ N/A Reviewed: ☐

Do you have thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have parathyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have adrenal gland problems?: ☐ Yes ☐ No

If yes, specify: _____

Have you been told you have Metabolic Syndrome?: ☐ Yes ☐ No

## NEUROLOGIC/EMOTIONAL FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions??

☐ Alzheimer's disease—***Cannot do this program*** ☐ Depression

☐ Anorexia (history of) ☐ Epilepsy--date of last seizure _____

☐ Anxiety ☐ Panic attacks

☐ Bulimia (history of) ☐ Schizophrenia

☐ Bipolar disorder ☐ Parkinson's **(NPA)**

If yes, taking Lithium? ☐ Yes **(NPA)**

***IMPORTANT--You must have your lithium levels monitored closely by the physician treating you for this disorder during weight loss. They may need to adjust your medication dosage as you lose weight.***

☐ Other : _____

## INFLAMMATORY CONDITIONS: ☐ N/A Reviewed: ☐

☐ Chronic fatigue syndrome ☐ Multiple sclerosis

☐ Fibromyalgia ☐ Osteoarthritis

☐ Lupus ☐ Psoriasis

☐ Migraines ☐ Rheumatoid arthritis

☐ Other autoimmune or inflammatory condition:

_____

## CANCER: Reviewed: ☐

**Have you ever had cancer?** ☐ No ☐ Yes **(NPA)**

What type and date of diagnosis?: _____

Do you have cancer now? ☐ No ☐ Yes

What type and date of diagnosis?: _____

Is your cancer in remission?: ☐ Yes ☐ No If yes, since when? _____

## GENERAL HEALTH: Reviewed: ☐

**Do you have sleep apnea?:** ☐ Yes ☐ No Since: _____

Do you have any other health conditions not discussed? ☐ Yes ☐ No

If yes, please note: _____

_____

## FOOD ALLERGIES: Reviewed: ☐

Do you have any food and/or supplement allergies or sensitivities? ☐ **Yes-- If yes, read disclaimer below** ☐ No

If yes, please specify: _____

**IMPORTANT**: If you have food and/or supplement allergies or sensitivities, it is the client's responsibility to review the entire list of ingredients of all products at every visit prior to purchase. There is a possibility that the manufacturers of all foods and/or supplements we sell could change the formulation at any time, without notice.

***Diet Mentor will not assume any liability for adverse allergic reactions to food and/or supplements consumed.***

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## EATING HABITS: (Please provide very honest answers) Reviewed: ☐

### BREAKFAST:

Do you eat **breakfast** every morning?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before lunch?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

### LUNCH:

Do you eat ***lunch*** every day?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before dinner?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

### DINNER:

Do you eat ***dinner*** every day?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before bed?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

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## OTHER: Reviewed: ☐

Are you a vegan?: ☐ Yes ☐ No ***If yes--vegans* do not qualify due to *too many dietary restrictions.***

Are you a vegetarian?: ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much and for how long? _____

**WATER**
How many 8oz. glasses of water do you drink daily?: _____

**COFFEE/TEA**
Do you drink coffee and/or tea on a daily basis?: ☐ Yes ☐ No

If yes, how much coffee/tea do you drink per day and what size?: _____

What do you put in your coffee/tea?: _____

**SODA**
Do you drink any soda? ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

***IMPORTANT: Please do not abruptly decrease soda consumption due to caffeine withdrawal. Decrease slowly and aim to discontinue altogether within a couple weeks.***

**JUICE**
Do you drink any juice?: ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

**ALCOHOL**
Do you drink alcohol?: ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

***IMPORTANT ABOUT ALCOHOL*:** When the body is in the state of ketosis, the liver and kidneys are producing glucose to maintain proper blood sugar levels (gluconeogenesis). Alcohol can stop the production of sugar in the liver. This can lead to a potentially dangerous low blood sugar (hypoglycemia). Thus, drinking alcohol while on this program can cause you to pass out without warning and possibly damage your brain.

Drinking alcohol is not part of this program and also usually leads to poor eating choices which will affect your results.

Coach initial that this disclaimer was read to the client: _____

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## MEDICATIONS & SUPPLMENTS INCLUDING OVER-THE-COUNTER:

**Please lists all prescription medications and supplements you currently take.**

**Refer to the example in line one. If you take no medications, please check box below.**

❑ **Check this box if you take no medications or supplements and initial here: _____**

| Name of medication | Milligrams* per capsule | Number of capsules per day | Number of doses per day | Prescribing physician | Reason for taking this medication |
|---|---|---|---|---|---|
| Medication X | 500mg | 1 | 1 x per day | Dr. John Doe | **Reason/diagnosis** |
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**Reviewed** ☐

**CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES**

I confirm that the information that I have provided to Diet Mentor and that is recorded by me on this Health Profile is true, complete, and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that if I have any of the conditions marked NPA on this form, I understand that I should not be undertaking or otherwise following the diet protocol if I have any of the said conditions or if I am currently taking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on Diet Mentor protocol, ii) remain under the supervision of said medical doctor while I am on Diet Mentor protocol and iii) provide documentation confirming the foregoing.

I understand that if 1) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, 2) have not disclosed same to the Diet Mentor and iii) nevertheless chose to follow on Diet Mentor protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Diet Mentor as well as Diet Mentor, their parent companies, subsidiaries and affiliates and each of their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "Releasees") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision of following Diet Mentor protocol.

I confirm that Diet Mentor protocol has been explained to me, that I have had the opportunity to ask questions relating to Diet Mentor protocol, that I have been provided with the answers to such questions, and that I understand the importance of strictly following Diet Mentor protocol for best results as explained to me verbally and in the materials provided to me, both before and during the period I will be following the Diet Mentor protocol.

Without limitation to the foregoing, I confirm that I have been advised that because Diet Mentor protocol limits the ingestion of certain foods, it is mandatory that I consume the required vitamins and minerals while I am on the Diet Mentor protocol.

I undertake to disclose immediately to the Diet Mentor and/or my physician **any and all changes in my health status**, discomfort, symptoms, upcoming surgeries, or any other health concerns that I may experience while I am following the Diet Mentor protocol.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules of the Arbitration Act or similar statute of my state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

**Client name (printed):** _____

_____

**Client Signature** ***(or guardian—list relationship)*** **Date**

# Coaching Agreement

Please read this document carefully. Please do not sign this agreement unless all your questions have been answered and you fully agree with everything below. This signed agreement will be kept on file. You can request a copy any time by submitting in writing to: info@dietmentor.com

**Who is health coaching for?**
Health coaching is for people who want to make improvements in their health and well-being. It is through this process that clients gain knowledge, skills, and confidence to make lasting and positive behavioral changes that leads to a long-term healthy lifestyle!

Due to our educational and knowledge-based dietary approach, we want you to make a commitment to yourself and this program before we accept you as a client. We want you to be healthier and lose weight, but first you must have the desire to do so. Results on our program are repeatable and predictable. We feel passionately that we cannot fulfill our promise to you if you do not strictly adhere to either protocol. We have developed this agreement for Diet Mentor participants to not only help them lose weight and get healthy but also continue living a healthy lifestyle. Congratulations for taking this important step toward creating a healthier life for yourself!

**Confidentiality:**
We follow all HIPAA guidelines. All information shared is kept confidential. The Notice of Privacy Practices can be found in full on our website, is hung up at all locations, as well as available anytime you request a copy.

By signing this agreement, I give my coach permission to correspond with me by phone, email, and text including sending documents.
Important: E-mail and text is not guaranteed confidential and is not HIPAA compliant. By signing below I understand and agree.

We agree to maintain, store, and dispose of any records, including electronic files and communications, created during coaching interactions in a manner that promotes confidentiality, security, and privacy and complies with any applicable laws, regulations, and agreements.

**Nondiscrimination Policy:**
We refrain from unlawful discrimination in occupational activities, including age, race, gender, orientation, ethnicity, sexual orientation, religion, national origin, or disability; and will consistently demonstrate dignity and respect in all professional relationships.

**Disclaimer:**
Weight loss results can vary depending on the individual. There are no guarantees of specific results. The client releases the coach of all liability pertaining to the services rendered in the coaching relationship.

**Termination:**
Our program is 100% voluntary. Clients can terminate at any time.

**Feedback:**
***We love feedback!*** If you have any questions or comments, please e-mail info@dietmentor.com. You can also contact us through our secure website contact form located on our website: www.DietMentor.com

**Products and Coaching Services:**
The products and services recommended are those that we endorse. The quality and quantity of coaching services as defined are in no way dependent in any way upon the purchase of any additional products or services by the client other than those outlined and agreed upon in this Coaching Agreement per the Program Pricing and Fee Structure.

**Payments:**
Payment is expected at the time of service. Payment can be made by credit card, debit card, cash, or check or a mixture of the forementioned at the time of service unless special arrangements have been made and agreed upon in advance by management. Many clients use flexible spending, health savings, or other forms of health insurance incentive cards. Please note, we do not directly participate with any specific insurance plans and each plan works differently. It is the customer's responsibility to inquire about participation and reimbursement.

**Price Disclaimer:**
We reserve the right to change our pricing for products and/or services at any time without prior notice.

**Refund/Exchange Policy:**
We do not offer refunds on any products or services. We will gladly exchange any product listed for individual sale that has not been opened or used. We do not exchange or refund opened boxes not listed for individual sale.

**Role of the Health Coach:**

- Coaching will be an ongoing relationship that may take a number of months/years, although either party can terminate at any time. This program is 100% voluntary.

- The coach is not functioning as a licensed medical professional. The coach does not diagnose or treat. We recommend you consult with your physician regarding any medical or medication changes as well prior to starting our program or any weight loss program.

- The coach will provide healthy lifestyle recommendations only. Our recommendations are not meant to take the place of a licensed healthcare provider.

- The coach is not functioning as a licensed mental health professional. We do not provide therapy, counseling, life coaching, treatment for mental illness, recovery from past abuse, psychiatric interventions, treatment for substance abuse, and/or addictive behavior, including eating disorders such as anorexia nervosa, bulimia, and/or binge eating disorders. We also do not provide legal or financial counsel.

- Coaching is most effective when both parties are honest and straightforward in all communication.

- We will respect your time, honor your goals, and answer your questions with experience, quality, and most of all compassion.

- Coaching can involve brainstorming, the completion of written assignments, education, goal setting, identifying plans of action, accountability, making requests, agreements to change behavior, examining healthy lifestyles, and questioning.

- The client is the ultimate decision maker regarding any changes in their lifestyle. We believe in the term "bio-individuality" which means what works for one person, may not work for you and vice versa.

- Coaching is a confidential relationship. The coach agrees to keep all information confidential following HIPAA guidelines, except in those situations where such confidentiality would violate the law.

- The coach does not seek to impose his or her values, convert, condemn, or refuse coaching services to people who do not share similar values and beliefs.

- The coach agrees to return calls, e-mails, and texts within 24 hours of receipt of contact method during business hours. Regarding any contact on weekends or holidays when we are closed, we will make every effort to respond as quickly as possible or by the next business day.

- Conflict of Interest: A situation in which a coach has a private or personal interest sufficient to appear to influence the objective of their professional role or responsibilities as a coach. Coaching is a professional client relationship and there are clear boundaries that cannot be crossed. Coaches are bound to abide by the highest ethical principles and personal code of conduct. Sometimes we must have difficult conversations or show "tough love" regarding following our protocol, policies, and procedures. Therefore, to avoid any conflict of interest, coaches and clients cannot be friends. We will, however, help you in any way we can with your weight loss and health journey.

**Role of the Client:**

- The client agrees it is their responsibility to discuss their involvement in our program, any medical issues, prescription changes, or dietary supplements with their primary care provider or other licensed medical specialist that currently treats them. We will send your provider a consent to sign for certain medical conditions outlined on the Health Profile.

- The client agrees to attend their appointments *every* week while on Phases 1-3 to remain active. Consistent attendance provides for the greatest opportunity of success, which is why we schedule you for the same day and time each week. Not coming weekly should be the exception and not the norm. We are always very flexible with rescheduling to another day/time during the same week. *Please notify us immediately by phone or e-mail if you need to change your appointment day/time.*

- The client agrees to purchase the required boxes of protein products and pay the weekly program fee every week while on the program regardless of attendance.

- The client agrees if they are sick or cannot make their appointment *for any reason* and cannot reschedule for another day that week, to remain active in our program you must call us and place your order over the phone and have a friend or family member pick up your food. We can process your credit card payment over the phone and will have your order ready for pickup.

- The client agrees if they are going out of town the following week *for any reason*, to remain active in our program, you must pay that week's Program Fee and purchase the required food in advance for the week they will miss.

- The client agrees that there may be times where the clinic may need to reschedule or even cancel a client's weekly appointment due to a holiday, staffing shortage, staff vacation, required continuing education, weather, or other extenuating circumstances. The client agrees to remain active in our program, you must pay each week's Program Fee and purchase the required food for the week they will miss regardless of who cancels and/or the reason.

- The client agrees with the No Show Policy which is: If you fail to contact us via phone, e-mail, and/or text that you cannot attend your appointment, you will be marked as a "No Show". All future appointments will be removed and you will need to do an official "Restart" to become active again.

- The client agrees to follow the program exactly as written making no customized modifications. It is simple, if you choose not to follow the protocol, you will not get the typical results expected.

- The client agrees to consume only Diet Mentor protein products—Substitutions are not allowed and consumption will affect your results.

- The client agrees to take all mandatory supplements daily unless it is agreed upon in advance and/or due to a physician's specific orders to not take certain supplements. Not taking the supplements could affect your health and slow down your weight loss results.

- The client agrees to journal their daily intake of food, fluids, and supplements in either a paper journal or an app and will provide same to coach at each appointment.

- The client agrees to abstain from drinking alcohol while on Phases 1-3. It will affect your results and it is dangerous to drink alcohol while on this protocol. Drinking alcohol usually leads to poor eating choices which adds carbs/calories and will affect results.

- The client agrees to be seen by various coaches. We cannot guarantee you will see the same coach at every visit.

- The client agrees to be honest and straightforward in all communication.

- The client agrees to be weighed and measured at each appointment. No avoiding the scale. Body fat readings are completed once per month in Phase 1-3 and every visit in Phase 4.

- The client agrees to complete each phase in its entirety. Phase 1 should be followed until you reach your goal weight. Phase 2 and 3 are 2 weeks in length.

- The client agrees to receive FREE unlimited coaching in Phase 4, the following guidelines must be met: You must reach your goal weight given at your initial consultation. Your goal weight must be between 22 - 28 on the BMI scale.

- The client agrees that to maintain weight loss, it is **strongly** recommended to continue coming for at least one full year after reaching your goal weight for best results. Studies have proven if you can keep your weight off for at least a year, you will most likely keep it off because you have changed your lifestyle. ***Keeping extra weight off takes continued effort and commitment, just as losing weight does.***

- I agree to participate in Diet Mentor's weight loss program as outlined above.
- I agree to "opt in" to receive text messages and e-mails regarding my appointments with Diet Mentor. You can "opt out" at anytime by replying "STOP".
- I agree to the Pricing Policy and Fee Structure. Any questions I have regarding fees and pricing have been answered.
- I have been informed and understand that drinking alcohol while on the program is dangerous for my health and could result in serious injury. Therefore, I agree to abstain from drinking alcohol while on this weight loss protocol. If I do drink alcohol, it is of my own volition, and I accept that it will also affect my weight loss results.
- I understand that I could be seen by various coaches throughout my weight loss journey.
- I have been informed and understand that the possible benefit of this program is not guaranteed.
- I understand that if I have food and/or supplement allergies or sensitivities, it is the client's responsibility to review the entire list of ingredients of all products at every visit prior to purchase. There is a possibility that the manufacturers of foods and/or supplements we sell could change the formulation at any time, without notice. Diet Mentor will not assume any liability for adverse reactions to food and/or supplements consumed.
- I understand that Diet Mentor does not offer refunds on any services or products.
- I understand that Diet Mentor reserves the right to change our pricing for products and/or services at any time without prior notice.
- I understand that I have the right not to participate in this program and can discontinue for any reason.
- I understand that I have the right to ask questions and to know the purpose and objectives of the program.
- I agree to follow the No Show Policy which was explained to me and a copy provided. If you fail to contact us via phone, e-mail, and/or text that you cannot attend your appointment, you will be marked as a "No Show". All future appointments will be removed and you will need to do an official "Restart" to become active again.
- The client agrees if they are sick or cannot make their appointment *for any reason* and cannot reschedule for another day that week, to remain active in our program you must call us and place your order over the phone and have a friend or family member pick up your food. We can process your credit card payment over the phone and will have your order ready for pickup.

**I hereby consent to Diet Mentor's weight loss program. Failure to comply with any policies could result in termination from the program.**

Signed in _____(city/state), on this _____day of _____, 20 _____.

Coach name (printed): _____

Client name (printed): _____

_____ _____

**Client signature** **Coach Signature**

## ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

- I have received the summary page of Diet Mentor's Notice of Privacy Practices.
- I understand that I have access to the full notice at any time I request it.
- I understand that the full Notice of Privacy Practices are available on the website (www. DietMentor) or any time I request them.
- I understand that I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

May we discuss your weight loss journey with any member of your family? ***If so, please provide name below:***

_____

_____

**Name--*Please print clearly***

_____

**Signature** **Date**

**For Office Use Only**

**We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:**

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining the Acknowledgment**
- ☐ **Other (Please Specify) _____**

_____

_____

**Office staff signature** **Date**