Nutrition Solutions

12911 120th Avenue NE • Suite B50 • Kirkland, WA 98034 • (425) 825-8088

Consent for Treatment

I, the undersigned, voluntarily consent to receive medical nutrition therapy services from Debie McSperitt RDN, CD. I have read and understood all of the information provided. I understand that as with all medical treatment, there is no implied or stated guarantees that this treatment will offer improvement or a complete resolution to any or all conditions that I may have. I understand that Nutrition Solutions will keep a record of the healthcare services provided to me, which will be kept for a minimum of three but no more than seven years, after the date of my last visit. This record will be confidential and will not be released to others unless so directed by myself, my legal representative, or unless required by law.

This consent shall be in effect for the duration of treatment.

______________________________	______________________________
Patient's Name (Please Print)	Signature
______________________________	
Date	

Consent for Treatment for a Minor or Dependent Adult

If the patient is a minor, a dependent adult, or for whatever reason not responsible for the services rendered, the person signing this contract accepts full responsibility. This person agrees to all of the terms as specified for the professional services rendered to the patient.

______________________________	______________________________
Name of Person Responsible (Please Print)	Signature
______________________________	______________________________
Date	Relationship