Hope Traditional Wellness

Certified Nutritional Counseling

NEW CLIENT PACKET

Client Name: _____

Client Email: _____

Client Phone Number: _____

This New Client Packet (see attached) includes the following forms:

☑ WAIVER AND RELEASE

☑ NEW PATIENT/CLIENT REGISTRATION

Please print and complete the New Client Packet and present during initial appointment. Please request your appointment via the contact form on the website, or via a phone call. You will be contacted by Joel Olson, CNC within 3-5 business days upon receiving your email to schedule your initial appointment. In addition, please provide the following forms with your first appointment.

☐ **Any lab work from your medical record.**

☐ **A list of any current medications you are on.**

☐ **A list of any supplements you are currently taking.**

Please contact Joel Olson by email or call by telephone at (806) 674-6996 to cancel or reschedule any appointments.

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WAIVER AND RELEASE FOR NUTRITION COUNSELING

Hope Traditional Wellness and its Practitioners do not diagnose disease. You should consult a Physician before undergoing any dietary or food supplement changes. Any recommendations you follow for changes in diet, including but not limited to the use of food supplements are entirely your responsibility.

In consideration of my participation in nutrition counseling, I hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release the above named Institution, its employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in nutrition counseling, whether caused by negligence of Hope Traditional Wellness, its employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described nutrition counseling session.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN NUTRITION COUNSELING AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Signature of Patient/Client _____ Date _____

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NEW PATIENT/CLIENT REGISTRATION

Name			
Home Address			
	Street		
	City	State	Zip Code
Contact Information (✓ check preferred method of contact)			
	Home Phone	☐	Cell Phone
	Work Phone	☐	Email Address
Occupation			
Individual responsible for charges			
	Name		Phone Number
Referred by			
Referral Reason			
Current Physician			
	Name		Phone Number

Acceptance of Registration Information: I hereby accept the registration information written above as accurate and acknowledge this information will be used to guide the Registered Dietitian in preparing my personalized plan of care.

Signature of Patient/Client _____ Date _____

Background: I hereby certify that the information above is complete and accurate.

Signature of Patient/Client _____ Date _____