Medical Nutrition Therapy Clinic

Informed Consent and Liability Waiver Release for Participation in Medical Nutrition Therapy

I, ____, hereby expressly and

affirmatively states that I wish to participate in medical nutrition therapy.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in any nutrition therapy. I represent and warrant that I have no medical condition or any food restrictions that would prevent my full participation in medical nutrition therapy.

I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, that I might incur because of participating in nutrition therapy. I knowingly, voluntarily, and expressly waive any claim I may have against Dr. Jayashree Sanghavi for injury or damages that I may sustain because of participating in nutrition therapy.

I have had an opportunity to ask questions. Any questions that I have asked have been answered to my complete satisfaction. I understand the risk of my participation in this Medical Nutrition Therapy and knowing and appreciating these risks, I voluntarily choose to participate.

Participants Name (Please Print): ____________________________________

Birthdate: ____

Emergency Contact: _____________________________________ Phone: _____________________

Participant's Signature: ___________________________________ Date: _______________________

(Parent's Signature if under 18 years of age)

I represent that I have legal capacity and authorize to action on behalf of the minor named herein.

Parent/Guardian Signature: ___________________________________Date: ____________________