KMS Nutritional Services, LLC

Kristen Sugarman, RD Kelly Davidson, RD

Consent to Treatment

I,_____ , acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the Registered Dietitian (RD) named below. I understand that developing a treatment plan with this RD and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this RD.

I am aware that I may stop my treatment with this RD at any time. If I do, I will have to pay for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am agreeing to receive appointment reminders and other communication via text message regarding patient care to the cell phone number provided on the release of information.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the RD may stop my treatment.

I am aware that if I no show for 3 or more appointments or have 3 or more appointments unpaid, the RD has the right to terminate care.

My signature below shows that I understand and agree with all of these statements.

_____

Signature of client or legal representative Printed name Date

_____

Printed name of legal representative Relationship to client

I, the RD, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of RD Date

Copy accepted by client or Copy kept by RD

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.