CLIENT NAME:_____ PHONE:_____

EMAIL:_____

Total Nutrition Technology Informed Consent, Agreement and Guidelines Form

I hereby consent to voluntary participation with Total Nutrition Technology Inc., herein after referred to as TNT. TNT's services have been explained and I fully understand both the risks and benefits of the program. Furthermore, the level of training and credentials of those providing the service have been disclosed to me. All costs of these sessions have been outlined for me as well.

TNT will provide leadership to direct my weight/health management program, monitor my performance, and evaluate my progress. I agree to inform TNT of any changes that occur in my health or medications during my participation that may not be documented on the TNT Evaluation Form.

I have been provided with the duration of time it may take for me to reach my desired goal and I understand that it is my responsibility to contact my medical doctor for any medical issues that arise while participating in the TNT program.

INITIAL_____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of any insurance benefits to be made directly to TNT. I authorize and direct all insurance entities to furnish TNT with all information regarding my benefits, status of claim, reasons for non-payment and other information deemed necessary by TNT. INITIAL_____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I authorize TNT to furnish necessary medical information relating to this treatment to any insurance company, governmental or charitable agency and their agents, and other professional review organization with whom I may have insurance coverage or who may be assisting in payment of my medial expenses. I also authorize TNT to release any medical information to my referring physician, treating physician, consulting physicians, and hospital based physicians, as well as, to any licensed provider, health care agency, or medical or nursing facility to which I am referred or transferred for further medical care.
This authorization shall remain in effect unless revoked by me. INITIAL_____

PRIVACY

I have been provided with the opportunity to review the *Notice of Privacy Practices* document which describes how TNT will use and disclose my information and informs me of my rights relating to my information. The terms of TNT's Notice of Privacy Practices may change from time to time. A copy of the current Notice of Privacy Practices is posted in the office or I can obtain a revised version by contacting TNT's main office at (704) 549-9550. All communication with patients over the Internet (including email and fax) and telephone will have adequate security controls; however it is understood that electronic transmittal, wireless telephone communication and web-based systems are subject to difficulties and TNT cannot guarantee confidentiality of such technology. INITIAL_____

Please confirm phone numbers and/or email address that TNT can call/write to confirm appointments and/or discuss treatment plans.

CAN LEAVE MESSAGE ON VOICEMAIL: YES / NO

APPOINTMENT CANCELLATION/NO SHOW POLICY

Nutritional counseling sessions with the Registered Dietitian can range between 30-90 minutes. I understand complete personal attention cannot be given to me unless all of my scheduled appointments are attended and on time. For this reason, it is in my best interest to come to each session on time, prepared, and keep to the relevant topic. Cancellation of appointments will not be accepted without a **24-hour notice**. If I am unable to make my appointment, I understand that there will be a $25.00 courtesy fee charged to my credit card. I give TNT consent to charge $25.00 to my credit card (secured on file) for not adhering to this policy. INITIAL_____

FINANCIAL RESPONSIBILITY

- As a courtesy, TNT will check my eligibility for nutritional counseling benefits but will not be held responsible for an incorrect benefit summary provided by BCBS. I have been advised to contact member services/refer to my benefit booklet to confirm benefits as well.
- For all services not covered or deemed not medically necessary by my health plan, I agree to accept financial responsibility and to pay TNT directly. I understand that full payment is due within thirty (30) days of billing or as otherwise arranged by mutual consent of both parties.
- In the event I choose to continue with TNT's services I understand it will be an out-of-pocket expense at TNT's reduced rate of $55 per 30-minute session.
- If I pay more than what I owe for any service, I agree it can be used to pay for any unpaid bills I have with TNT. If there are no outstanding bills with TNT, I will be refunded this money. INITIAL_____

I acknowledge that I have read this document in its entirety and consent to and agree with the program as explained. Furthermore, I have given accurate information to the best of my knowledge regarding my current health risk and condition. I hereby release TNT and its officers, employees and independent contractors, including but not limited to consultants from any and all claims for damages.

SIGNATURE	DATE	GUARDIAN NAME
CLIENT NAME (CLEARLY PRINT)	TNT REPRESENTATIVE	GUARDIAN SIGNATURE