Joint Ventures SM
Physical Therapy and Fitness

JointVenturesPT.com
phone (617) 536-1161 fax (617) 536-1165

NUTRITIONAL COUNSELING INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of nutritional counseling treatments and other procedures within the scope of the practice of nutritional counseling on me (or on the patient named below, for whom I am legally responsible) by the nutritional counselor named below and/or other licensed nutritional counselor who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for the nutritional counselor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: recommendations regarding nutritional habits, physical activity and sleep habits. There is no obligation to implement the recommendations and alternative treatment may include no treatment.

I will notify a clinical staff member who is caring for me if I am or become pregnant.
I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in nutritional counseling. I realize that my participation in this activity involves risks of injury including but not limited to: cardiovascular and orthopedic type injuries, serious disabling injuries, and even the possibility of death. I also recognize that there are many other risks of injury that may arise due to my participation in this activity, and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating, understanding, and anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risks which could occur by reason of my participation. I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and I voluntarily choose to participate, assuming all risks due to my participation.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (or Patient representative, please indicate relationship)	(Date)
X	

PRACTITIONER SIGNATURE	(Date)
X	

Appointment Cancellation Policy
We require 24 hours' notice for any cancellations; otherwise you will be responsible for paying your usual treatment fee.
Appointments may be canceled by calling (617) 536-1161.

Appointment No-Show Policy
When you set an appointment, our receptionist sets aside time in the schedule just for you, so we can be certain to provide you the care you need. We value your time and know you value ours. If you cannot come to your appointment and haven't cancelled, you will be charged a regular appointment fee. If you are using a promotional gift certificate such as Groupon, we will redeem your gift certificate as being used.

Please Initial here:_____ to confirm that you agree to our policies and agree to make payment for missed appointments