Sol Acupuncture Health Solutions

Nutrition Services Consent to Treat

I, _____, hereby authorize Heidi Eberhardt, Licensed Acupuncturist and Clinical Nutrition Counselor at Sol Acupuncture Health Solutions, to provide nutritional counseling services, including any of the following methods as necessary to give proper assessments, determine treatment approaches, and treat or otherwise address my health concerns:

Methods, Procedures and Therapeutic Approaches

- **Dietary Advice and Therapeutic Nutrition**;
- **Lifestyle Counseling;**
- **General Diagnostic Procedures:** including but not limited to general physical exam, observation, palpation, and musculoskeletal assessments.

I understand that the nutritional counseling services are providing information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my overall health and wellness. I understand the purpose of nutrition counseling and the benefits and risks, if any, associated with counseling.

I understand that Heidi Eberhardt is a Licensed Acupuncturist and Certified Whole Food Nutrition Counselor and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to food, dietary supplements, and behaviors associated with eating. I understand nutrition counseling is not intended for the diagnosis of any disease and is not a substitute for medical diagnosis, treatment, and/or care of a disease by a medical provider.

I agree to hold Heidi Eberhardt and Sol Acupuncture Health Solutions harmless for claims or damages in connection with our work together. This is a contract between myself, Heidi Eberhardt and Sol Acupuncture Health Solutions and I understand that it is also a release of potential liability.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to this service, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Patient or Legal Representative Signature: _____

Printed Name of Above: _____

Date: _____