CONSENT FOR TREATMENT THROUGH LIFESTYLE & DIET CHANGES

Name: …… Birth Date
……./……./……
Address:
Telephone Numbers:
Email:

I have given all the information and have not hidden anything important from the doctor. During the consultation my present condition, its cause and how I can reverse it will be explained to me. I will also be explained the nutrition regimen, how it will help me regain my health, and what changes I should expect. I understand that this is a lifestyle that I will have to continue even after I become well so as to not get sick again. Regular lab reports may be necessary to be sure that the improvement is occuring and to enable reductions in medications. I understand that by registering for this consultation, I have decided to take responsibility for my health.
I understand that each individual and their disease is unique. I do take full responsibility of my health. I understand that I should inform doctor if ever my health takes a turn for the worse. I will not blame the doctor if I do not get cured of my disease.

I agree to follow the recommended suggestions to get the results through nutrition.

Signed: Date:

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