Nutritional Direction P.A.

The following information is for your file in our office and will remain in the strictest confidence.

Date_____

Name_____

Address_____

_____

Telephone – Cell_____ Office_____ Email_____

Height_____ Weight_____ Age_____ Date of Birth_____

Name and phone number of relative or close friend in case of emergency_____

Chief concern/s about my health and/or reason I have chosen to see the Nutritionist _____

_____

_____

Our sessions will be kept in complete confidence (except to collaborate with your primary or other health care professionals when and if necessary). Our recommendations are not intended to diagnose or treat any specific illness or disease. It is our firm belief that the body, given the proper support, can seek out and heal the root causes of disease.

DISCLAIMER

I, _____, (name) hereby attest to the following:

1. I fully understand that Sharon R. Price, Ph.D., CN, is not a medical doctor and that I am not here for medical diagnostic or treatment procedures.
2. The services performed by Dr. Price are at all times restricted to consultation on the subject of natural health and are intended for the maintenance of the best possible state of health and do not involve the diagnosing, prognosticating, or treatment of disease.
3. That I am here, on this and any subsequent visit, solely on my own behalf.

_____ _____

(Client Signature) (Parent/Guardian Signature if under 18 years of age)

IMPORTANT: **On your first visit, please bring all supplements and prescription medications that you are currently taking.** Also, bring a copy of blood work done within the last 12 months. Please keep a 3-day consecutive food diary of everything that you eat and drink. Do not modify any of your food intake. It is necessary for you to be as candid as possible in this and all areas to assess an accurate picture of your current nutritional status.

As a common professional courtesy, if it becomes necessary to reschedule your appointment, please make the arrangements at least forty-eight (48) hours in advance.

We would like to thank the person who referred you to our offices _____.

Sharon R. Price, PhD., CN Nutritional Direction. P.A.

www.nutritionaldirection.com drprice@nutritionaldirection.com

817-797-7475

Nutritional Direction P.A.

 Date _____

We are delighted you have chosen the path to wellness and health. It is a journey we will make together by supporting and encouraging you as you progress. You are making a lifestyle change that takes patience and dedication.

I, _____ (name), understand and will comply with the following:

1. If you are unable to keep the appointment time that has been reserved for you, please notify us at least forty-eight-hours (48-hours) prior to the appointment so that we may open up this time for those who are waiting.
2. Missed appointments, cancellations or reschedules inside the forty-eight-hour (48-hour) period will be charged a $50.00 fee.
3. The returned check fee is $25.00.

_____ _____

(Client Signature) (Parent/Guardian Signature if under 18 years of age)

Please refer to **"Testing and Screening"** for further details. Prices are not listed for these services because of the frequency of change.

We accept check or cash, and all major credit cards.

Dr. Sharon R. Price Counseling Session Fees:
Fifty-five (55) minutes - $ 135.00
Thirty minutes - $ 70.00

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