Consent for Treatment and Authorization

I hereby consent to participating in nutrition counseling at Balance and Nourish, LLC and understand that all information I provide is private, confidential, and protected by law. When necessary to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

Insurance Company_____

Member ID:_____ Date of Birth:_____

Address:_____

Physician_____ Phone #_____

Therapist/Counselor_____ Phone #_____

Additional Provider_____ Phone #_____

Additional Provider_____ Phone #_____

☐ I hereby give my clinician at Balance and Nourish permission to speak with and disclose my protected health information with the above-named treatment providers.

☐ I acknowledge I have been provided a copy of Balance and Nourish, LLC HIPAA Notice of Privacy Practices and that a copy is always available at www.balanceandnourishRD.com.

Printed Name (Client) _____

Signature (Client)_____ Date:_____

Signature (Guardian)_____ Date:_____