INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELING

I am employing the counseling services of Ashley Downes of Fitfuel Nutrition, LLC ("**Company**") so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my health and wellness.

I understand that Ashley Downes is a Nutritionist and Nutrition Educator and does ***not*** dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is ***not*** a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Nutritional evaluation or testing provided in counseling is not intended for the diagnoses of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

I understand that Ashley Downes and Company will keep notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location.

Medical records, personal information and history divulged in session to Ashley Downes will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release.

I further acknowledge and agree that I am solely responsible for obtaining any physician, therapist, or other medical approval that I may need for any exercise or conditioning program and that I have not consulted with or relied upon any representations by the Company or Ashley Downes for any medical advice or consultation.

I agree to hold Ashley Downes and Company harmless for claims or damages in connection with our work together. This is a contract between myself and the Company, and I understand that it is also a release of potential liability.

I understand that the Company has a **24-hour cancellation policy**, and I am aware that I may be charged a fee for a missed appointment if proper notice is not given (by phone or email).

Payment is required at the time of service.

Nutrition counseling services may be terminated at the discretion of the Company if written notification is provided to a client 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.

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Client or Guardian's Signature Date

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Print Name