

SHAPE Program

Informed Consent & Acceptance of Responsibility

Patient/Client Informed Consent:

I, _____, understand that the SHAPE Program is a lifestyle modification and health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary healthcare experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustments. I agree to notify my prescribing physician that I am working with _____ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutrition protocol will be recommended based on my unique health history, urinalysis and symptoms.

Shelly Meier N.D., NUTRITION OUTLET Statement of Intent:

I/We, _____, understand that my/our intent and responsibility is to determine if the SHAPE Program would be beneficial for assisting your body in its innate healing process. Our first appointment with you will be multi-faceted. We agree to do the following:

- Take full health history and assess your unique needs.
- Discuss your health goals.
- Perform a baseline urinalysis.
- Make specific recommendations as necessary (nutrition, supplements, diagnostics).
- Determine a follow-up schedule.

Patient/Client Acceptance of Responsibility:

I have been informed and understand that nutritional and lifestyle recommendations may involve certain risks. These may include, but are not limited to, detoxification symptoms, such as: initially feeling worse due to the release of stored toxins, digestive symptoms, fatigue, headaches, muscle or joint pain, allergic reactions or any unpredictable reaction with my prescribed medications that has not been found in research literature. In addition, I agree to do the following:

- Submit full health history.
- Discuss my health goals.
- Have consistent urinalyses and follow-up visits as recommended by my SHAPE practitioner.
- Read the Program Guidebook.
- Review the information provided on the SHAPE ReClaimed website.
- Be aware that I can join the "OFFICIAL SHAPE ReClaimed Support Group" on Facebook and will not substitute recommendations from Facebook for my specific health needs.
- Notify my prescribing physician, _____, that I am working with Shelly Meier N.D., @ NUTRITION OUTLET and will be closely monitored while incorporating this program.

I have read (or have had read to me) the above information. I have had the opportunity to ask questions about its contents and by signing below, I agree to these conditions for the duration of my SHAPE Program journey.

Name (Print)

Signature

Practitioner Name (Print)

Date Signed

