Disclaimer Statement

The information that Vital Nutrition for Health provides you is for informational purposes only. This information is not intended to be substituted for seeking professional medical advice, diagnosis or treatment. This information is for education purposes and is not intended for the mitigation, cure, or treatment of medical conditions. Always seek the advice of a medical professional.

Client Agreement and Release Form

I fully understand that Beth Winter MNT, Master Nutrition Therapist of Vital Nutrition for Health, is not a medical doctor and I am not here for medical diagnostic or treatment procedures.

I understand and agree to accept and pay for all nutritional consultation services provided by Beth Winter.

I understand that Beth Winter has graduated from Nutrition Therapy Institute as a Master Nutrition Therapist, which is accredited by the National Association of Nutrition Professionals. I understand she has over 5 years of experience and more than 600 hours of training.

I understand and agree that any services rendered by Beth Winter are not designed to cure or prevent any disease, pain, injury or mental or physical condition of any kind. I am here to learn how to nourish my health and well-being.

I understand these services are not a substitute for medical care and are not intended to diagnose, treat, alleviate or care for disease.

I understand these assessments serve as a guide to help me develop an appropriate nutrition program tailored to my individual needs and also help me monitor my progress in achieving my health goals.

Personal information supplied to Vital Nutrition for Health will be kept strictly confidential (unless I consent to sharing it).

This form is a release of potential liability. I agree to hold Vital Nutrition for Health and its employees harmless for claims or damages in connection with our work together. My signature below confirms I have read, fully understand, and agree to all the above statements and agreements.

Signature_____ Date_____

Print Name_____

Consent of Services

I request that Beth Winter perform the following services:

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Signature of Client_____ Date_____

Print Name_____

Vital Nutrition for Health Business Policies

- *It is the policy of Vital Nutrition for Health that payment is due at the time of service unless other financial arrangements are made in advance. Please ask about our payment plan options.*
- *We accept payment in the form of cash, check, and all major credit cards. There will be $50.00 convenience fee for all returned checks.*
- *We require at least 24 hours notice for all canceled sessions. Failure to to do so will result in a $50.00 non-refundable cancellation fee.*

- *We know you time in valuable so we ask that you arrive on time to all sessions.*
- *While we do our best to accommodate all our clients' schedules, arriving late may result in reduced session time. If this occurs please be advised that you will still be charged for the full session.*
- *All supplements must be paid for in full at the time of pick up. Special orders must be paid for at the time the order is placed.*
- *Vital Nutrition for Health acknowledges that occasionally the Master Nutrition Therapist may have to prematurely terminate a client contract for the health and well-being of all parties involved.*

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