Nutrition Associates of San Antonio
Linda Farr, R.D., L.D.
4414 Centerview Drive. Suite 233
San Antonio, TX 78228

I, the undersigned, am the patient (or the patient's duly authorized representative) and do hereby voluntarily consent to:

CONSENT FOR MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy encompassing all nutrition assessment, nutrition diagnosis, nutrition interventions and nutrition monitoring considered necessary or advisable in the judgment of the Registered, Licensed Dietitian and/or the Physician. I am aware that nutrition is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of interventions.

AUTHORIZATION TO RELEASE INFORMATION

The release of any medical or other information necessary to coordinate medical or nutritional care or to process payment.

CONSENT TO PAY FOR SERVICES

Make complete payment by cash or check, at the end of each session, to Linda Farr RD/LD for Medical Nutrition Therapy services. I understand and agree that without proper prior authorization from either my primary care physician or insurance carrier, that all services rendered to me on this date may not be covered by my health care policy, and that I may not be reimbursed for these services.

SIGNATURE

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____

Signature of Patient or Responsible Party Date

_____

Witness