

## Nutrition Consultant Service Agreement

1. I, \_\_\_\_\_, am consulting with Kristine Flynn, MPH, Certified Nutrition Consultant for Pacific Coast Nutrition, a division of William F Flynn & Associates, Inc. (hereafter referred to as PCN), to gain information on health and wellness. I understand that Kristine Flynn is not a physician and that she does not dispense medical advice nor prescribe treatment. Rather, she provides information to enhance my knowledge of how nutritious foods, herbs, supplements, and lifestyle affect health.
2. Kristine Flynn's training includes a 4-year Bachelor of Science degree in Psychobiology, a two-year Master's program in Public Health with a specialization in Nutrition, and a Clinical and Sports Nutrition certification through Intrafitt Corporation. The methods of evaluation employed on my behalf, which may include diet, supplementation, and assessment analysis, are not intended to diagnose disease. I specifically authorize the use of these assessments, so that we can develop an appropriate dietary and health-supporting program for me, and to monitor my progress towards achieving my health goals.
3. These services are not a substitute for medical care, and do not claim to diagnose, treat, or alleviate disease. Nutrition consultation services are not licensed by the state of California, they are alternative or complementary to the healing arts services licensed by the state. For medical diagnosis and treatment of disease, I would need to consult with a medical physician, or other licensed healing arts practitioner.
4. I certify that I am here solely on my own behalf. I am not representing any other person, company, association, and/or on the behalf of any governmental agency.
5. I currently am \_\_\_ am not \_\_\_ under the care of a physician for a health problem or medical condition. If so, please describe.\_\_\_\_\_.  
I give Kristine Flynn permission to contact my physician, \_\_\_\_\_, at the following phone number \_\_\_\_\_ on my behalf. The purpose of this contact is to attain additional information from my doctor on his/her diagnosis or recommended treatment, in order that Kristine Flynn may work in concert with my physician to provide me with appropriate and complementary information.
6. I agree to hold Kristine Flynn and PCN harmless for claims or damages in connection with our work together. This is a contract between PCN and myself and a general release of liability for Kristine Flynn and PCN.
7. I understand PCN has a 48-hour cancellation policy, and I am aware that I will be charged a \$25 cancellation fee for a missed appointment if proper notice is not given (by phone NOT e-mail).
8. I agree to pay a total sum of \$\_\_\_\_\_ for nutritional services rendered.
9. For prepaid and discounted Nutrition Programs, unused portions are not refundable. It is highly recommended that Nutrition Programs be fully utilized within 6 months of their original purchase date, as this best serves client and practitioner objectives for motivation and timely results. Portions of prepaid programs will be forfeited if unused after 9 months.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

{Please keep a copy for your records}