ANNICK POIRIER
REGISTERED DIETICIAN

www.annick-poirier.com

I, _____hereby grant permission for Annick Poirier, R.D. to correspond with my physician(s) to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence. I further acknowledge the information provided to me by Annick Poirier is designed to meet my personal dietary needs. It is NOT suitable for any other individuals and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by Annick Poirier, I realize that it is important for me to inform either my physician or Annick Poirier of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/ or Annick Poirier. I will not hold my physician or Annick Poirier responsible for any complications that result from my failure to comply with either of the above. _____

I have agreed to have my Registered Dietitian keep records of our visits and to file these in a secure and appropriate place. I have agreed to have the Registered Dietitian contact other Health care Professionals if necessary to benefit in my care. This may be accomplished by letter, phone, fax, or email (per PIPEDA). _____

Recommendations by Annick Poirier, R.D. are not intended to replace the advice of a physician or health professional nor to diagnose, treat or cure any health problems. Please consult your physician or a health professional before beginning any diet or exercise program. This plan is the intellectual property of Annick Poirier, any copying or posting of this plan on a public forum or download site is forbidden. Annick Poirier does not assume any responsibility for injuries or health complications incurred during physical training or nutrition recommendation before during or after treatment._____

I authorize insurance companies to audit this form, and all documents pertaining to treatment and all file content. _____

I understand this is a health service therefore under no circumstance any refunds are issued. _____

Cancellation policy:
Twenty-four (24) hour notice is needed to cancel/reschedule your appointment. This allows our office to seek a replacement. If 24 hour notice is not provided, a fee of $95.00 will be charged to you or lose a session prepaid. Thank you for your cooperation and understanding.

Date: _____
Client's Signature: _____
If under the age of 18 parent or guardian signature:_____
Witness:_____