The Diet Center
Weight Loss Done Right!

Health Profile

Initial Consultation Date/Time:_____

The purpose of the health profile is not to establish a diagnosis but rather to determine your health status to guide your weight loss. ***We highly recommend you consult with your physician prior to starting any weight loss plan.***

Legend (For Office Use)

NPA = **Needs Physician Approval**

Overall (please print clearly)

First Name: _____ Last name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ E-mail: _____

Date of birth: _____ Age: _____ Height: _____

Profession: _____

What is your marital status?: ☐ Single ☐ Married ☐ Widow ☐ Divorce ☐ Other _____

How many children do you have_____ What are their ages?: _____

Who does most of the cooking at home?: _____

On average, how many hours do you sleep per night? _____

Referral Source (How did you hear about us?):_____

Current Weight: _____ Weight 1 year ago: _____ Minimum adult weight: _____ At age: _____

Do you exercise: ☐ Yes ☐ No If yes, what kind? _____

How often do you exercise? ☐ Daily ☐ Weekly ☐ Other _____

Have you ever been on a diet before?: ☐ Yes ☐ No
If yes, specify which diet(s) and why you think they did not work for you (i.e. too rigid, too much cooking, etc.)

_____

On a scale of 1 to 10, circle how important is it for you to lose weight and get healthy?
Least important **1 2 3 4 5 6 7 8 9 10** Very Important

Why do you want to lose weight? _____

FOR CLINIC USE ONLY:

START WEIGHT:	**GOAL WEIGHT:** **GOAL BMI:**
DIET START DATE:	**GOAL DATE:** **@** **/week**
3-DAY F/U DATE:	**PROGRAM:** PHASE 1 ☐ ALTERNATIVE ☐
PHYSICIAN CONSENT REQUIRED: **YES** **NO**	**DATE PHYSICIAN CONSENT FAXED:**

PERCENTAGES: **10--** **20--** **30--** **40--** **50--**

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PHYSICIANS: Reviewed: ☐

Who is your primary care physician: _____

Please list any other physicians who treat you and their specialty:

Physician name: _____Specialty: _____

Physician name: _____Specialty: _____

Physician name: _____Specialty: _____

Physician name: _____Specialty: _____

DIABETES: ☐ N/A Reviewed: ☐

Do you have diabetes: ☐ Yes ☐ No ***If no, please skip to next section***

If yes, which type: ☐ Type 1—Insulin dependent (insulin injections only)—**ALTERNATIVE PROTOCOL ONLY**

☐ Type 2—Insulin dependent (diabetic pills, and/or insulin injections)

Is your blood sugar monitored? ☐ Yes ☐ No If yes, how often?: _____

If so, by whom?: ☐ Myself ☐ Physician ☐ Other _____

Do you tend to be hypoglycemic?: ☐ Yes ☐ No ***If yes, please inquire about our alternative protocol.***

NOTE: If you are currently on Sodium-Glucose Co-Transporter inhibitor medication (SGLT-2), which include Ebymect, Edistride, Forxiga, Invokana, Jardiance, Synjardy, Vokanamet and Xigduo, YOU CANNOT START OR BE ON THE REGULAR PROTOCOL. Please speak to your coach about our Alternative Protocol.

CARDIOVASCULAR FUNCTION: ☐ N/A Reviewed: ☐

Do you or have you had any of the following conditions?:

☐ Arrythmia **(NPA)**
☐ Blood clot **(NPA)**
☐ Coronary artery disease **(NPA)**
☐ Heart attack **(NPC)—*Must be 6 months post***
☐ Heart valve problem **(NPA)**
☐ Heart valve replacement **(NPA)**
☐ Hyperlipidemia (high cholesterol/triglycerides)
☐ Hyperkalemia (high potassium) **(NPA)**
☐ Hypokalemia (low potassium) **(NPA)**
☐ Hypertension (high blood pressure) **(NPA)**
☐ Pulmonary embolism **(NPA)**
☐ Stroke or transient ischemic attack **(NPA)**
☐ Congestive heart failure **(NPA)**
☐ Please select one (if applicable)
☐ History of congestive heart failure
☐ Current congestive heart failure

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

Have you ever had any type of heart surgery? ☐ Yes ☐ No
If yes, what type and when?: _____

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KIDNEY FUNCTION: ☐ N/A Reviewed: ☐

Have you had any of the following conditions?:

☐ Kidney disease **(NPA)**

☐ Kidney transplant **(NPA)**

☐ Kidney stones—***Must drink 80-100oz water daily***

☐ Do you presently or have you ever had gout? ☐ Yes ☐ No If yes, since when?: _____

If yes, what medication has been prescribed?: _____

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

LIVER FUNCTION: ☐ N/A Reviewed: ☐

Have you ever had any liver conditions?: ☐ Yes ☐ No

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

COLON FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Constipation
☐ Crohn's disease
☐ Diarrhea
☐ Diverticulitis
☐ Irritable bowel syndrome
☐ Ulcerative colitis

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

DIGESTIVE FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Acid reflux
☐ Celiac disease
☐ Gastric ulcer **(NPA)--If yes, is your ulcer healed?** ☐ Yes ☐ ***No—If no, cannot do this program***
☐ Gluten intolerance
☐ Heartburn
☐ History of bariatric surgery **(NPA)**
If yes, date and type of surgery and current status: _____

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

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OVARIAN/BREAST FUNCTION: ☐ N/A Reviewed: ☐

Do you currently have any of the following conditions?:

☐ Amenorrhea ☐ Irregular periods

☐ Fibrocystic breasts ☐ Menopause

☐ Heavy periods ☐ Painful periods

☐ Hysterectomy ☐ Uterine fibroma

Date of last menstrual cycle: _____

Are you taking or on any type of contraceptive birth control? ☐ Yes ☐ No
If yes, IMPORTANT--Changes in weight and/or estrogen levels may render birth control methods less effective and could result in pregnancy. Please discuss with your gynecologist a back-up or barrier birth-control method.

Are you pregnant? ☐ Yes ☐ No ***If yes--CANNOT do program***

Are you breastfeeding ☐ Yes ☐ No ***If yes--CANNOT do program***

ENDOCRINE FUNCTION: ☐ N/A Reviewed: ☐

Do you have thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have para thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have adrenal gland problems?: ☐ Yes ☐ No

If yes, specify: _____

Have you been told you have Metabolic Syndrome?: ☐ Yes ☐ No

NEUROLOGIC/EMOTIONAL FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions??

☐ Alzheimer's disease—***Cannot do this program*** ☐ Depression

☐ Anorexia (history of) ☐ Epilepsy--date of last seizure _____

☐ Anxiety ☐ Panic attacks

☐ Bulimia (history of) ☐ Schizophrenia

☐ Bipolar disorder ☐ Parkinson's **(NPA)**
If yes, taking Lithium? ☐ Yes
(NPA)— VERY IMPORTANT--*You must have your lithium levels monitored closely by the physician treating you for this disorder during weight loss. They may need to adjust your medication dosage as you lose weight.*

☐ Other : _____

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INFLAMMATORY CONDITIONS: ☐ N/A Reviewed: ☐

☐ Chronic fatigue syndrome
☐ Multiple sclerosis
☐ Fibromyalgia
☐ Osteoarthritis
☐ Lupus
☐ Psoriasis
☐ Migraines
☐ Rheumatoid arthritis
☐ Other autoimmune or inflammatory condition:

_____

CANCER: Reviewed: ☐

Have you ever had cancer? ☐ No ☐ Yes **(NPA)**

What type and date of diagnosis?: _____

Do you have cancer now? ☐ No ☐ Yes**—Cannot do program**

What type and date of diagnosis?: _____

Is your cancer in remission?: ☐ Yes ☐ No If yes, since when? _____

GENERAL HEALTH: Reviewed: ☐

Do you have sleep apnea?: ☐ Yes ☐ No Since: _____

Do you have any other health conditions not discussed? ☐ Yes ☐ No

If yes, please note: _____

_____

FOOD ALLERGIES: Reviewed: ☐

Do you have any food and/or supplement allergies or sensitivities? ☐ **Yes-- If yes, read disclaimer below** ☐ No

If yes, please specify: _____

IMPORTANT: ***If you have food and/or supplement allergies or sensitivities, it is the client's responsibility to review the entire list of ingredients of all products at every visit prior to purchase. There is a possibility that the manufacturers of all foods and/or supplements we sell could change the formulation at any time, without notice.***

The Diet Center will not assume any liability for adverse reactions to food and/or supplements consumed.

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EATING HABITS: (Please provide very honest answers) Reviewed: ☐

BREAKFAST:

Do you eat **breakfast** every morning?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before lunch?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

LUNCH:

Do you eat ***lunch*** every day?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before dinner?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

DINNER:

Do you eat ***dinner*** every day?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you snack before bed?: ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples: _____

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OTHER: Reviewed: ☐

Are you a vegan?: ☐ Yes ☐ No ***If yes--vegans <u>CANNOT</u> do program due too many dietary restrictions.***

Are you a vegetarian?: ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much and for how long? _____

<u>WATER</u>
How many 8oz. glasses of water do you drink daily?: _____

<u>COFFEE/TEA</u>
Do you drink coffee and/or tea on a daily basis?: ☐ Yes ☐ No

If yes, how much coffee/tea do you drink per day and what size?: _____

What do you put in your coffee/tea?: _____

<u>SODA</u>
Do you drink any soda? ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

IMPORTANT: Please do not abruptly decrease soda consumption due to caffeine withdrawal. Decrease slowly and aim to discontinue altogether within a couple weeks.

<u>JUICE</u>
Do you drink any juice?: ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

<u>ALCOHOL</u>
Do you drink alcohol?: ☐ Yes ☐ No

If yes, what kind, how many, and how often?: _____

***<u>IMPORTANT ABOUT ALCOHOL</u>*:** When the body is in the state of ketosis, the liver and kidneys are producing glucose to maintain proper blood sugar levels (gluconeogenesis). Alcohol can stop the production of sugar in the liver. This can lead to a potentially dangerous low blood sugar (hypoglycemia).

Thus, drinking alcohol while on this program can cause you to pass out without warning and possibly damage your brain. Drinking alcohol also usually leads to poor eating choices which will affect your results.

Coach initial that this disclaimer was read to the client: _____

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MEDICATIONS & SUPPLMENTS INCLUDING OVER-THE-COUNTER:

Please lists all prescription medications and supplements you currently take.

Refer to the example in line one. If you take no medications, please check box below.

❑ **Check this box if you take no medications or supplements and initial here: _____**

Name of medication	Milligrams* per capsule	Number of capsules per day	Number of doses per day	Prescribing physician	Reason for taking this medication
Medication X	500mg	1	1 x per day	Dr. John Doe	**Reason/diagnosis**

*Or grams, mEq, or dosage unit your physician prescribes.

Reviewed ❑

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CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES

I confirm that the information that I have provided to The Diet Center Weight Loss Done Right (the "Center") and that is recorded by me on this Health Profile is true, complete, and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that if I have any of the conditions marked NPA on this form, I understand that I should not be undertaking or otherwise following the diet protocol if I have any of the said conditions or if I am currently taking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on The Diet Center Weight Loss Done Right protocol, ii) remain under the supervision of said medical doctor while I am on The Diet Center Weight Loss Done Right protocol and iii) provide documentation confirming the foregoing.

I understand that if 1) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, 2) have not disclosed same to the Center and iii) nevertheless chose to follow on The Diet Center Weight Loss Done Right protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Center as well as The Diet Center Weight Loss Done Right, their parent companies, subsidiaries and affiliates and each of their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "Releasees") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision of following The Diet Center Weight Loss Done Right protocol.

I confirm that The Diet Center Weight Loss Done Right protocol has been explained to me, that I have had the opportunity to ask questions relating to The Diet Center Weight Loss Done Right protocol, that I have been provided with the answers to such questions, and that I understand the importance of strictly following The Diet Center Weight Loss Done Right protocol for best results as explained to me verbally and in the materials provided to me, both before and during the period I will be following The Diet Center Weight Loss Done Right protocol.

Without limitation to the foregoing, I confirm that I have been advised that because The Diet Center Weight Loss Done Right protocol limits the ingestion of certain foods, it is mandatory that I consume the required vitamins and minerals while I am on The Diet Center Weight Loss Done Right protocol.

I undertake to disclose immediately to the Center and/or my physician **any and all changes in my health status**, discomfort, symptoms, upcoming surgeries, or any other health concerns that I may experience while I am following The Diet Center Weight Loss Done Right protocol.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules of the Arbitration Act or similar statute of my state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

Client name (printed): _____

_____

Client Signature ***(or guardian—list relationship)*** **Date**

Coaching Agreement

Please read this document carefully. Please do not sign this agreement unless all your questions have been answered and you fully agree with everything below. This signed agreement will be kept on file.

You can request a copy any time by submitting in writing to: info@thedietcenter.com.

Who is health coaching for?
Health coaching is for people who want to make improvements in their health and well-being. It is through this process that clients gain knowledge, skills, and confidence to make lasting and positive behavioral changes that leads to a long-term healthy lifestyle!

Due to our educational and knowledge-based dietary approach, we want you make a commitment to yourself and this program before we accept you as a client. We want you to be healthier and lose weight, but first you must have the desire to do so. Results on our program are repeatable and predictable. We feel passionately that we cannot fulfill our promise to you if you do not strictly adhere to either protocol. We have developed this agreement for The Diet Center Weight Loss Done Right participants to not only help them lose weight and get healthy but also continue living a healthy lifestyle. Congratulations for taking this important step toward creating a healthier life for yourself!

Confidentiality:
We follow all HIPAA guidelines. All information shared is kept confidential. The Notice of Privacy Practices can be found in full on our website, is hung up at all locations, as well as available anytime you request a copy.

By signing this agreement, I give my coach permission to correspond with me by phone, email, and text including sending documents.
Important: E-mail and text is not guaranteed confidential and is not HIPAA compliant. By signing below I understand and agree.

We agree to maintain, store, and dispose of any records, including electronic files and communications, created during coaching interactions in a manner that promotes confidentiality, security, and privacy and complies with any applicable laws, regulations, and agreements.

Nondiscrimination Policy:
We refrain from unlawful discrimination in occupational activities, including age, race, gender, orientation, ethnicity, sexual orientation, religion, national origin, or disability; and will consistently demonstrate dignity and respect in all professional relationships.

Disclaimer:
Weight loss results can vary depending on the individual. There are no guarantees of specific results. The client releases the coach of all liability pertaining to the services rendered in the coaching relationship.

Termination:
Our program is 100% voluntary. Clients can terminate at any time.

Feedback:
We love feedback! If you have any questions or comments, please e-mail info@thedietcenter.com. You can also contact us through our secure website contact form at located on our website: www.TheDietCenter.com

Products and Coaching Services:
The products and services recommended are those that we endorse. The quality and quantity of coaching services as defined are in no way dependent in any way upon the purchase of any additional products or services by the client other than those outlined and agreed upon in this Coaching Agreement per the Program Pricing and Fee Structure.

Payments:
Payment is expected at the time of service. Payment can be made by credit card, debit card, cash, or check or a mixture of the forementioned at the time of service unless special arrangements have been made and agreed upon in advance by management.
Many clients use flexible spending, health savings, or other forms of health insurance incentive cards. We do not directly participate with any specific insurance plans and each plan works differently. It is the customer's responsibility to inquire about participation and reimbursement.

Refund/Exchange Policy:
We do not offer refunds on any products or services. We will gladly exchange any product listed for individual sale that has not been opened or used. We do not exchange or refund opened boxes not listed for individual sale.

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Role of the Health Coach:

- Coaching will be an ongoing relationship that may take a number of months/years, although either party can terminate at any time. This program is 100% voluntary.

- The coach is not functioning as a licensed medical professional. The coach does not diagnose or treat. We recommend you consult with your physician regarding any medical or medication changes as well prior to starting our program or any weight loss program.

- The coach will provide healthy lifestyle recommendations only. Our recommendations are not meant to take the place of a licensed healthcare provider.

- The coach is not functioning as a licensed mental health professional. We do not provide therapy, counseling, life coaching, treatment for mental illness, recovery from past abuse, psychiatric interventions, treatment for substance abuse, and/or addictive behavior, including eating disorders such as anorexia nervosa, bulimia, and/or binge eating disorders. We also do not provide legal or financial counsel.

- Coaching is most effective when both parties are honest and straightforward in all communication.

- We will respect your time, honor your goals, and answer your questions with experience, quality, and most of all compassion.

- Coaching can involve brainstorming, the completion of written assignments, education, goal setting, identifying plans of action, accountability, making requests, agreements to change behavior, examining healthy lifestyles, and questioning.

- The client is the ultimate decision maker regarding any changes in their lifestyle. We believe in the term “bio-individuality” which means what works for one person, may not work for you and vice versa.

- Coaching is a confidential relationship. The coach agrees to keep all information confidential following HIPAA guidelines, except in those situations where such confidentiality would violate the law.

- The coach does not seek to impose his or her values, convert, condemn, or refuse coaching services to people who do not share similar values and beliefs.

- The coach agrees to refrain from unlawful discrimination in occupational activities, age, race, gender, orientation, ethnicity, sexual orientation, religion, national origin or disability; and will consistently demonstrate dignity and respect in all professional relationships.

- The coach agrees to return calls, e-mails, and texts within 24 hours of receipt of contact method during business hours. Regarding any contact on weekends or holidays when we are closed, we will make every effort to respond as quickly as possible or by the next business day.

- The quality of coaching services and the quantity of coaching as defined in this coaching agreement is not to be dependent in any way upon the purchase of any additional products or services by the client above what is outlined in our Program Pricing and Fee Schedule.

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Role of the Client:

- The client agrees it is their responsibility to discuss their involvement in our program, any medical issues, prescription changes, or dietary supplements with their primary care provider or other licensed medical specialist that currently treats them. We will send your provider a consent to sign for certain medical conditions outlined on the Health Profile.

- The client agrees to attend their appointments *every* week while on Phases 1-3. Consistent attendance provides for the greatest opportunity of success, which is why we schedule you for the same day and time each week. Not coming weekly should be the exception and not the norm. We are always very flexible with rescheduling to another day/time during the same week. *Please notify us immediately by phone or e-mail if you need to change your appointment day/time.*

- The client agrees if they are sick or cannot make their appointment *for any reason* and cannot reschedule, to call us and place your order over the phone and have a friend or family member pick up your food. We can process your credit card payment over the phone.

- The client agrees if they are going out of town the following week *for any reason*, you pay that week's Weekly Program Fee in advance and receive all food and vitamins for the week they will miss.

- The client agrees if they need to cancel an appointment without rescheduling the same week *for any reason*, they will still be required to pay the previous week's Weekly Program Fee the following week at the next appointment to remain active and continue with coaching.

- The client agrees with the Late Cancel/No Show Policy which is: There is a $25 fee applicable to be paid to continue if you no show or late cancel with less than 24 hours notice of your appointment as it is usually too late for us to fill the open appointment slot. This is above the Weekly Program Fee amount owed.

- The client agrees to follow the program exactly as written making no customized modifications. It is simple, if you choose not to follow the protocol, you will not get the typical results expected.

- The client agrees to consume only The Diet Center Weight Loss Done Right protein products—Substitutions are not allowed, and consumption will affect your results.

- The client agrees to take all mandatory supplements daily unless it is agreed upon in advance and/or due to a physician's specific orders to not take certain supplements. Not taking the supplements could affect your health and slow down your weight loss results.

- The client agrees to journal their daily intake of food, fluids, and supplements in either a paper journal or an app and will provide same to coach at each appointment.

- The client agrees to abstain from drinking alcohol while on Phases 1-3. It will affect your results and it is dangerous to drink alcohol while on this protocol. Drinking alcohol usually leads to poor eating choices which adds carbs/calories and will affect results.

- The client agrees to be seen by various coaches. We cannot guarantee you will see the same coach at every visit.

- The client agrees to be honest and straightforward in all communication.

- The client agrees to be weighed and measured at each appointment. No avoiding the scale.

- The client agrees to receive FREE unlimited coaching in Phase 4, the following guidelines must be met: You must reach your goal weight given at your initial consultation. Your goal weight must be under 30 on the BMI scale; and/or your waist measurement must be 35 inches or less for women and 40 inches or less for men; and/or your body fat percentage must be in the healthy to high range.

- The client agrees to complete each phase in its entirety. Phase 1 should be followed until you reach your goal weight. Phase 2 and 3 are 2 weeks in length.

- The client agrees to be weighed, measured, and body fat percentage reading at every visit.

- The client agrees that to maintain weight loss, it is **strongly** recommended to complete all phases and continue coming for at least one full year after reaching your goal weight for best results. Studies have proven if you can keep your weight off for at least a year, you will most likely keep it off because you have changed your lifestyle. ***Keeping extra weight off takes continued effort and commitment, just as losing weight does.***

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Program Pricing and Fee Structure:

Initial Consultation is $375. This appointment is 1.5 hours and includes:

- Medical history review
- Medication review
- Initial weight and body measurements
- Body fat composition
- Before photos
- Explanation of protocol and questions answered
- The Inner Diet Program
- 3 boxes of food/protein products @ $23.00 per box
- 3 required vitamins @ no charge (Multi, Essential Minerals, Essential Fatty Acids)
- Extra items purchased are voluntary and are an additional charge

Phase 1 is $85 per week and includes:

- 15-minute coaching appointment
- Weight and body measurements
- Body fat composition
- Journal review
- Client questions, obstacles, motivation, education reviewed
- Weekly program fee is $16.00
- 3 boxes of food/protein products required @ $23.00 per box
- Required vitamins @ no charge (Multi, Essential Minerals, Essential Fatty Acids)
- Extra items purchased are voluntary and are in addition to the $85 program price
- Weekly scheduled private coaching appointments and unlimited e-mail/phone call coaching as needed

Phase 2 and 3 is $62 per week and includes:

- 15-30 minute coaching appointment
- Weight and body measurements
- Body fat composition
- Journal review
- Client questions, obstacles, motivation, education reviewed
- Weekly program fee is $16.00
- 2 boxes of food/protein products required @ $23.00 per box
- Extra items purchased are and are in addition to the $62 program price
- Weekly scheduled private coaching appointments and unlimited e-mail/phone call coaching as needed

Phase 4 is $0.00 (FREE) and includes:

- Monthy 15 minute maintenance coaching appointments for as long as the client follows the Phase 4 guidelines.
- The purchase of any items is 100% voluntary

Restart Fees:

If you have been off Phase 1 for 30 days or more and decide to restart, the restart price will be $130 and that fee includes:

- 3 boxes of food/protein products @ 23.00 per box
- 3 required vitamins @ $60 (Multi, Essential Minerals, Essential Fatty Acids)

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CONSENT TO PARTICIPATE

- I agree to participate in The Diet Center Weight Loss Done Right's weight loss program as outlined above.
- I agree to the above Pricing Policy and Fee Structure. Any questions I have regarding same have been answered.
- I have been informed and understand that drinking alcohol while on the program is dangerous for my health and could result in serious injury. Therefore, I agree to abstain from drinking alcohol while on this weight loss protocol. If I do drink alcohol, it is of my own volition and I accept that it will also affect my weight loss results.
- I understand that I will be seen by various coaches throughout my weight loss journey.
- I have been informed and understand that the possible benefit of this program is not guaranteed.
- I understand that if I have food and/or supplement allergies or sensitivities, it is the client's responsibility to review the entire list of ingredients of all products at every visit prior to purchase. There is a possibility that the manufacturers of foods and/or supplements we sell could change the formulation at any time, without notice. The Diet Center will not assume any liability for adverse reactions to food and/or supplements consumed.
- I understand that The Diet Center Weight Loss Done Right does not offer refunds on any services or products.
- I understand that I have the right not to participate in this program and can discontinue for any reason.
- I understand that I have the right to ask questions and to know the purpose and objectives of the program.
- I understand that I will be charged a Late Cancellation Fee of $25.00 if I fail to give at least 24-hour notice prior to canceling my appointment. A copy of the Cancellation and No-Show Policy has been provided and explained at my initial consultation.
- I understand that I will be charged a No-Show Fee of $25.00 if I fail to show for my appointment. I understand I must pay this fee at my next appointment to continue with your program and purchase products. A copy of the Cancellation and No-Show Policy has been provided and explained at my initial consultation.
- I understand that to receive FREE unlimited coaching in Phase 4, the following guidelines must be met: You must reach your goal weight given at your initial consultation. We do not adjust your goal weight to accommodate weight gain or stopping short of our goal. Your goal weight must be under 30 on the BMI scale; your waist measurement must be 35 inches or less for women and 40 inches or less for men; and/or your body fat percentage must be in the healthy to high range.

Having read the above in its entirety, I hereby consent to The Diet Center Weight Loss Done Right weight loss program. Failure to comply with the above could result in termination from the program.

Signed in _____(city/state), on this _____day of _____, 20 _____.

Coach name (printed): _____

Client name (printed): _____

_____ _____

Client signature **Coach Signature**

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

- I have received the summary page of The Diet Center Weight Loss Done Right's Notice of Privacy Practices.
- I understand that I have access to the full notice at any time I request it.
- I understand that the full Notice of Privacy Practices are available on the website (www.TheDietCenter.com) or any time I request them.
- I understand that I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

May we discuss your weight loss journey with any member of your family? ***If so, please provide name below:***

_____

_____

Name--*Please print clearly*

_____

Signature **Date**

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining the Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Office staff signature **Date**