STSP™ Informed Consent

Clinical Nutrition Program

Please read, fill in blanks, sign , and USPS mail Original to A.C.N. within 24 hours.

An **Informed Consent** communicates policies and procedures of ***Advanced Clinical Nutrition (A.C.N.)***, so that A.C.N. may provide their services and ministry with clarity and my "consent." This Informed Consent is about my Clinical Nutrition Program (Supplemental, Dietary & Lifestyle), therefore:

1. I understand that A.C.N. Services provide Nutritional Evaluations, Assessments and/or Clinical Nutrition Analysis of Laboratory Testing, to design a Clinical Nutrition Program (or Therapy) that consists of therapeutic and maintenance supplements, dietary education, guidelines and plans and/or lifestyle education, for the purpose of improving my health, and not for the diagnosis, treatment or prescription for any medical symptom, disease, disorder or condition. Therefore, I understand that it is my responsibility to seek medical attention if I suspect or have a disease, disorder or condition. **Please Initial Here_____**

2. Because the lifespan of the red blood cells is three months, I understand that it may take at least three months to replace nutrient-depleted, toxic red blood cells with healthy new cells. Consequently, I understand that this is required before my body can begin healing the cells of my tissue, organs, glands, body systems and physical structure. Therefore, I agree to give my Clinical Nutrition Program **at least** three months before I evaluate its effectiveness.

3. I understand that though it takes three months for my body to begin healing at a cellular level, I may experience improvement in my nutritional symptoms as early as three days to six weeks after beginning my Clinical Nutrition Program. Why? Because as my body becomes more nourished and less toxic, my biochemistry starts to return to a state of ease and symptoms begin to leave. Disease is the state of dis-ease in the body.

4. I understand that other factors, not related to nutritional biochemistry, such as lifestyle behaviors, medications, stress, exposures, etc., can interfere with the effectiveness of my clinical nutrition health improvement program. Therefore, I acknowledge that there is no guarantee regarding the success of my program and I hold Dr. Smith, ***Advanced Clinical Nutrition***, its staff and affiliates, blameless in regards to my clinical nutrition program.

DATE:_____CLIENT SIGNATURE:_____ BIRTHDATE:_____

My signature and initials apply to me and any minor children I enroll in STSP, who are biologically mine or I am their legal guardian.

STSP™ Informed Consent

Clinical Nutrition Program

Please read, fill in blanks, sign , and USPS mail Original to A.C.N. within 24 hours.

5. I understand that though biochemical testing of blood, urine, saliva, stool or hair is not part of the STSP program, some policies related to these tests have been included in this document in the event that I or another STSP client requires additional help to succeed in improving their health.

6. I understand that the dispensing of therapeutic supplements requires a Nutritional Evaluation, Nutritional Assessments, and/or Clinical Nutrition Analysis of the Laboratory testing of my biochemistry (blood, urine, hair, saliva, and stool), whichever applies to me. Therefore, to stay in Clinical Nutrition Therapy, I agree to obtain timely Re-Evaluations and/or Retesting of Lab tests, whichever applies.
Please Initial Here_____

7. Should I require biochemical testing, I understand that in addition to updated Re-Evaluations, the dispensing of therapeutic supplements also requires monitoring monthly **Progress Reporting** telephone consultations with Dr. Smith, until I am able to resume STSP without the need for biochemical testing or consultations.

8. I understand that the first Nutritional Re-Evaluation or Retesting is required in the fourth month, after starting my clinical nutrition program due to the lifespan of the red blood cells, and the results of each updated Nutritional Evaluation, Biochemical tests, and Supplement Healing Pace determines the date for the next retesting. **STSP™** Guidelines are provided to calculate the date for my Nutritional Re-Evaluations.
Please Initial Here_____

9. I understand that my improved progress is dependent upon my consistency in taking my therapeutic and/or maintenance supplements, making dietary and lifestyle changes, increasing my education, and raising my standard of health. I understand the **STSP™** program or system is providing foundational and basic education regarding these goals.

10. Therefore, I understand that when I am ready, I may request advanced education and Clinical Nutrition Services at any time to build upon the **STSP™** foundation. I may also request this should it be determined that I have, in due time, received the maximum benefits of the STSP program and my specific nutritional biochemical requirements now exceed the scope of the **Self-Therapy Supplement Program (STSP™).**

DATE:_____CLIENT SIGNATURE:_____ BIRTHDATE:_____

My signature and initials apply to me and any minor children I enroll in STSP, who are biologically mine or I am their legal guardian.

STSP™ Informed Consent

Clinical Nutrition Program

Please read, fill in blanks, sign , and USPS mail Original to A.C.N. within 24 hours.

11. I understand that unsupervised, unapproved, arbitrary changes to the **STSP™** "Supplement" Program Instructions and "Supplement" Program Design written documents can result in sabotaging my healing progress. Therefore, I agree to adhere to my program design instructions as directed and as written in the **STSP™** documents, without making arbitrary changes and take full responsibility should I choose to do otherwise.

12. Should I desire to change any part of the guidelines or instructions regarding the "design" of my **STSP™** Supplement Program, for any reason, I understand that consulting with Dr. Smith first is my best insurance against my unknowingly sabotaging the successful results of my health improvement that is possible utilizing the **STSP™** system.

My signature on each of the three pages of the "**STSP™** Informed Consent – Clinical Nutrition Program" acknowledges that I read, understood, and agree to adhere to these policies and I am retaining the clinical nutrition ministry services of ***Advanced Clinical Nutrition (A.C.N.).***

I agree to re-read all policy documents for answers before contacting A.C.N., thus limiting direct questions to rulings on topics not included in their written policies.

I understand that lack of adherence to policies listed in #18-#22 on the "**STSP™ Informed Consent – Business Policies"** is subject to termination of services and all policies are upheld by A.C.N., without exception.

DATE:_____CLIENT SIGNATURE:_____ BIRTHDATE:_____
My signature and initials apply to me and any minor children I enroll in STSP, who are biologically mine or I am their legal guardian.

PRINT FULL NAME:_____DAY PHONE: _____

(No P.O. Boxes)
HOME ADDRESS:_____CITY/STATE_____ZIPCODE_____

My signature and initials on each page of all Informed Consents apply to me and any minor children I enroll in STSP, who are biologically mine or I am their legal guardian.