The Low Carb Healthy Fat Dietitian

Intake Form and Service Option Form

Full Name (First, Middle Initial, Last):			
Former Name/ Maiden Name (if applicable):			
Date of Birth (DD / MM / YYYY):		Current Age (in years):	
Gender:	Male ☐	Female ☐	
Street Address (number,street name, apt #):			
Mailing Address (if different than above):			
City:		Province/State:	
Country:		Postal Code/Zip:	
Occupation:			
Phone Number(s) with area code:			
Email:			
Emergency Contact Name:		Emergency Contact Number:	
MD's Name:		MD's Phone Number:	
MD Diagnosis (list all):			
MD Recommendations:			
How did you hear about us?	Please select an item from the dropdown menu		
Please enter specific details (name of friend, doctor, event, etc.):			
Is there a mental health component to this consultation?	◯ Yes	◯ No	
Kind of nutrition support you have had:			
Previous diets followed (if any):			
Date of Last Blood Tests: (required):		Abnormal Results: ◯ Yes	◯ No
Current Blood Pressure: (required):		Date of Blood Pressure: (required):	

Note: Please send a pdf (Adobe) copy of your **most recent complete blood test results** with **this form** to **info@lchf-rd.com**. If you don't have current complete blood work, we can get started without it, however I will need it prior to designing your Meal Plan.

Please select one (required):

☐ **Distance Consultation services** (phone/skype)

☐ **In-person services** (in Coquitlam office)

Do you have extended benefits (required):

◯ Yes — Extended Benefits provider (required):

◯ No — Extended benefit limits for visits to a Dietitian (required): $ / year

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In one sentence, please describe your goals and expectations and lifestyle changes you would like to make. Please be as specific as possible:

Please list any physical or mental health illnesses or conditions that run in your family (parents, grandparents, siblings):

Please list any medical conditions that you have been diagnosed with (e.g.Type 2 Diabetes, hypertension, high cholesterol, etc.)

Please list all physician-diagnosed allergies that you have (foods, drugs, environmental):

Please list any food intolerances you have (foods that make you feel unwell):

Please list the names of all **medications*** and/or **nutritional supplements** currently being taken, as well as the dosage:

***Please note that I do not provide weight management services to clients currently on insulin or insulin-analogue therapy. Please consult with a healthcare professional with CDE certification.

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Prices are in **Canadian dollars (CDN).** GST (5%) will be added.

1. HOURLY SESSIONS:

☐ **Hourly Clinical Services:** provides the services as available under one of the packages, but on an hourly basis. — $150 / hr

2. COMPLETE ASSESSMENT PACKAGE:

☐ **The Complete Assessment Package** is an all-inclusive package for clients who want to eat healthier, lose weight and lower their insulin resistance. The Package includes a one-hour initial appointment to establish dietary goals, collect personal and family medical history, review any recent laboratory tests (blood work, etc.) and conduct a complete food habit and lifestyle review. Based on the information collected, an Individual Meal Plan (1 hour service) will be designed for you, factoring in your weight management goals (one-hour). Review of your Meal Plan, teaching of simple yet accurate ways to estimate portion sizes, and answering questions will take place during the final one-hour Nutrition Education Session. — $350 / pkg

3. FOLLOW-UP PACKAGES:

☐ **Dietary Management Package:** The Dietary Management Package is a follow-up package for those who've taken the Complete Assessment Package and would like additional support or 'coaching' as they become fat-adapted. The Dietary Management Package can be taken as 6 half-hour sessions or as 3 one hour-sessions – or a combination of full hour and half hour sessions totalling 3 hours of services. — $350 / pkg

☐ **Anti-Inflammatory Protocol (AIP) Package:** designed to help people learn how to limit foods that promote inflammation and to focus intake around foods that are evidence-based to have anti-inflammatory properties in order to reduce pain & joint stiffness. — $350 / pkg

4. CUSTOMIZED SERVICES:

☐ **Customized Nutrition Package:** (to be designed in consultation with you)

REGISTERED DIETITIAN SIGNATURE:

☐ I agree to provide the services outlined in the Customized Nutrition Package description at the following cost: $

Registered Dietitian's Printed Name:

Date: Day Month Year:

DISTANCE CONSULTATION and REGISTERED DIETITIAN REGISTRATION

For those taking Distance Consultation service, please note that my clinical office and place of business is British Columbia, Canada and I am registered with the College of Dietitians of British Columbia and Alberta and Distance Consultation services will be deemed to have taken place at my Coquitlam, British Columbia office.

SELECTION OF PACKAGES and PACKAGE EXPIRY

Complete blood test results will need to be received prior to the design of the Individual Meal Plan for those taking a Complete Assessment Package but the package may be started pending their reception. Packages must be completed within three (3) months from the date indicated at the bottom of this form, after which they will be deemed to have expired.

PAYMENT METHODS, RECEIPTS and CANCELLATION OF SERVICES

Payment in Canadian dollars (CDN) shall be made 24-hours' in advance of the first scheduled appointment either by e-transfer sent to info@lchf-rd.com (and using the security word provided) or paid via credit card directly on the SSL encrypted web page (www.lchf-rd.com). If attending appointments in-person, deposit for the first appointment shall be made via credit card or e-transfer but subsequent payments can be made via personal cheque made out to The LCHF Dietitian.

A flexible payment plan is available for the Complete Assessment Package, with payments as follows: $150 paid 24 hours' prior to the assessment appointment, $100 paid prior to design of Meal Plan, $100 paid prior to Nutrition Education Session.

Payments for packages that have already begun are non-refundable, however should the office receive written notice requesting cancellation of services 7 days or more prior to the first confirmed appointment, a full refund will be provided via e-transfer within 7 business days.

APPOINTMENT CANCELLATION, RESCHEDULING and 'NO-SHOWS'

Cancellation or rescheduling of an appointment with less than 24 hours' written notice will result in a $150.00 charge being applied.

Failure to keep an appointment ('no-shows') will be considered as a completed visit.

CONFIDENTIALITY

All discussions with the Dietitian and all records related to nutritional services are confidential and will not be shared with any other person, health care provider or organization without prior knowledge and written consent of the client.

For confidentiality, laboratory test results should have confidential information redacted prior to emailing to us.

ROLE OF THE CLIENT'S PHYSICIAN

The client's physician is responsible for overseeing their healthcare, and it is the client's responsibility to inform them that they are planning to consult with a Registered Dietitian. If their physician has specific dietary recommendations the client will request that their physician write a referral to the LCHF-RD with their instructions.

If the client does not have a General Practice / Family Practice Physician, they will consult with a physician at walk-in clinic regarding their intention to see a Registered Dietitian for low carbohydrate services and will ask them if they have any specific recommendations.

If the client has been prescribed medications to control their blood sugar, cholesterol or blood pressure, they understand that it is their responsiblity to ensure that they have a physician monitor their medication dosage as they lose weight.

STATEMENT OF UNDERSTANDING:

I hereby attest that I am seeking nutrition consultation session(s) on my own behalf in order to learn nutritional and lifestyle information that I may apply in everyday life.

Unless I provide the Dietitian with a written referral from my physician indicating otherwise, I understand and accept that the services provided by Joy Y. Kiddie, MSc RD of The LCHF Dietitian (a division of BetterByDesign Nutrition Ltd.) do not involve the diagnosis, treatment, mitigation or prevention of a disease or disorder or abnormal physical state or their symptoms and that I am providing lab tests results for information purposes only.

I understand and accept that Joy Y. Kiddie MSc, RD of The LCHF Dietitian (a division of BetterByDesign Nutrition Ltd.) is licensed as a Registered Dietitian in British Columbia and Alberta, Canada and can provide services in all provinces except PEI.

I am fully responsible for my own health and that recommendations provided to me do not replace, superced or subsitute for the diagnoses and treatment recommendations of my physician(s).

I understand and accept that it is my responsibility to consult with my physician [or in the absense of one, with a physician at a local walk-in clinic] with regards to implementing any recommendations provided to me *prior* to changing my dietary intake, eating pattern and/or physical activity.

I understand and accept that if decide to pursue a low carbohydrate diet that the initial Meal Plan that will be designed for me will be at a significantly reduced level of carbohydrates and will begin at 130g of carbohydrate per day (unless otherwise prescribed by my physician). Carbohydrates will be gradually reduced subsequently only as required to attain desired clinical outcomes.

I understand and accept that it is my responsibility to have clarifed anything I do not understand on this form with Joy Y. Kiddie, MSc, RD prior to signing the form.

I understand and accept that Joy Y. Kiddie MSc, RD of The LCHF Dietitian (a division of BetterByDesign Nutrition Ltd.) has the right to refuse treatment or terminate provision of services.

I understand and accept that services provided to me by Distance Consultation will be deemed to have taken place in Coquitlam, British Columbia, Canada.

CONSENT FOR NUTRITION SERVICES

I understand and accept that there are both benefits and risks involved with any nutrition or physical activity recommendations and I have, or will consult with my physician before implementing any nutritional, exercise or lifestyle recommendations provided to me by the Dietitian.

I understand and accept that this consent expires six (6) months from the date indicated directly below.

I hereby give my consent for the above indicated services.

Client's First Name, Middle Initial, Last Name:

☐ By checking off this box, I declare that I have read this form, understand and agree with its contents.

☐ By checking off this box, I agree to all the terms above and understand that my typed name below is as legally binding as my physical signature.

Client's signature: (required)

Date: (required)