Consent Form

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,

hereby request and consent to nutritional consulting for me and on behalf of my infant (for whom I am the legal guardian) with Bridget Young, PhD, CLC (Healthy Baby, LLC). I acknowledge I have had the opportunity to inquire about this consent form, and by signing below I agree to the following terms and conditions. I further acknowledge this consent form will cover the entire course of nutritional care/consulting.

# Payment

I acknowledge I have been informed in advance that this service is not covered by my health insurance plan and I will be responsible for payment of all consulting fees. Payment is due in full upon completion of initial consultation. By signing this waiver, I agree to accept full financial responsibility of all consulting sessions.

 I agree

# Our consultation(s) will be recorded:

I hereby give my consent for Dr. Young to record our conversation(s). The audio file(s) of our consultation(s) will be made available to me. I give my consent for Dr. Young to use clinical information obtained during our sessions for the education of other health care providers and mothers about infant feeding. In accordance with all applicable laws, included but not limited to HIPPA regulations, my baby and I won’t be personally identified in any way, but aspects of our situation might be described and discussed. I understand that for the initial consultation and all requested follow-up sessions, Dr. Young will protect the privacy of my personal information.

 I consent

# You are responsible for communication with you and your infant’s medical doctors:

I understand that consulting with Dr. Young is not a substitute for being treated by my primary-care provider(s) or other appropriate healthcare practitioner. I acknowledge that Dr. Young is not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. Nutritional advice is not a substitute for medical care and is only a complement to the care I receive elsewhere. I understand that any deviation from my healthcare provider(s) recommendations, or changes to the diet or care of my infant or me, should be discussed with my doctor(s) prior to implementation of any recommended plan.

I understand and am informed the questions asked by Dr. Young are not intended to diagnose disease. Rather, these questions are intended as a guide to develop an appropriate overall plan for feeding and caring for my infant. I further understand that any nutritional recommendations are designed to support my baby’s growing body. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for consultation(s) are final and no refunds will be issued.

 I understand

# Permission to contact health care provider

I hereby grant consent for information about this consultation to be mailed, faxed, or emailed to my or my infant’s attending physician/health care provider, if requested by me or if deemed necessary by Dr. Young or my primary care provider.

 I agree

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Infant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Infant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**I understand that checking the box below serves as my signature, and that I understand and agree to all of the above:**

** I understand and agree**