

# **Nutritional Oncology Research Institute**

## **Acknowledgment & Consent Form**

### **Section 1 – Acknowledgment of Treatment & Consent**

I, \_\_\_\_\_, understand that Mark Simon is a Clinical Nutritionist practicing in the State of California. Mark Simon's specialization is in providing nutritional support to assist in the process of healing from cancer. The nutritional counseling services provided are intended to augment conventional medical procedures and practices.

I understand and agree that Mark Simon may use any and/or all these modalities in order to assist me in healing from conditions believed to be related to nutritional imbalances, deficiencies or excesses.

Nutritional Supplements, Herbs, Plant-Based Diet, Fasting, Raw Food Diets, Juicing, Selective Amino Acid Restricted Diet, Supranutritional Doses of Nutraceutical Products

### **Section 2 – Responsibility**

I understand that the follow through and success of healing is completely in my hands, and that Mark Simon is simply a facilitator who empowers me through nutritional counseling so I can make informed decisions about my diet and lifestyle.

I understand that I am responsible for my own health, healing and well being.

I understand that Mark Simon cannot diagnose, treat, heal or cure me of anything.

### **Section 3 – Informed Consent**

I understand I have the ability to heal myself by taking care of my body, resolving my emotional issues, changing my thinking, believing my intuitive insights and following a course of treatment that works with nature than against it.

I understand that it is my responsibility to advise Mark Simon of any medications I take and of any therapies I am undertaking.

I understand that it is my responsibility to advise Mark Simon of any allergies or sensitivities I have.

I understand that nutritional healing is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.

INITIALS: \_\_\_\_\_

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### **Section 4 – Information to Prevent Harm**

I understand all healing may cause me some minor discomfort in the form of aches and pains, headache, emotional release and/or increased emotionality.

I understand that it is my responsibility to report all contraindications, and that they may result through no fault of myself or Mark Simon. If I have concerns about these things, I will keep Mark Simon fully advised so that intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that I may lose weight, have facial blemishes, become allergic to some foods or that these services may have no effect on me because of factors beyond my control or the control of Mark Simon.

I understand that my health and healing is my responsibility; and I choose to use the nutritional healing services of Mark Simon with full knowledge that the nutritional programs may cause unusual symptoms that are temporary.

I have reviewed appropriate use of all nutritional supplements and I hold Mark Simon harmless if I consent to therapeutic use of those supplements.

### **Section 5 – Client Confidentiality**

I understand Mark Simon will keep all information about me completely confidential unless I release her in writing or as required by law. I further understand Mark Simon will not acknowledge my presence or discuss anything with me publicly unless I initiate the conversation and the topics of discussion.

I understand my identity and any information about me, whether I share it with Mark Simon or he discovers it on his own, will be held in strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or in part at any time.

### **Section 6 – Conflict Resolution**

I agree to settle any disagreements I have with Mark Simon and if this is not possible, then I agree to turn our concerns over to professional mediation service to mediate an agreement acceptable to both myself and Mark Simon.

INITIALS: \_\_\_\_\_

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## Section 7 – Fees and Payments

I understand that I agree to pay the institute according to a payment plan that I have selected.

Hourly nutritional counseling services are available at \$225.00 per hour with a 1 hour minimum.

I understand that all fees help support the research and expansion efforts of the institute and also help provided services to patients with limited resources.

## Section 8 – Acknowledgment of Understanding

I have thoroughly read and understood all sections of this Acknowledgment & Consent Form, and I agree to pay Mark Simon for nutritional counseling.

Printed Name of Client: \_\_\_\_\_

Address: \_\_\_\_\_

State/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Name if other than client: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

INITIALS: \_\_\_\_\_