I, the undersigned, hereby confirm I wish to participate in assessments, activities, food tasting and planning related to services provided by Joda P. Derrickson, PhD, RDN, dba Lightshine Wellness.

If you understand and agree please affirm each statement, sign and date this form.

____1. **Risk and Acknowledgement of Assumptions.** I understand that new practices including trying new foods, supplements, exercises including stretching and lifestyle habits recommended by Joda P. Derrickson, PhD, RDN are done so with the intent to assist, based on the information provide. I understand participation is 100% voluntary agree with this assumption and assume all risks associated with my trial of any recommendations provided by Joda P. Derrickson, PhD, RDN.

____2. **Voluntary Consent.** I confirm that I have had opportunities to question any assessment, practice or recommendation provided by Joda P. Derrickson, PhD, RDN. I choose to voluntarily participate, and realize I can stop at any time, and refuse to participate in some or part of the activities, as I see fit.

____3. **Health and Medical Acknowledgement.** I acknowledge that Joda P. Derrickson, PhD, RDN, wants met to be healthy, fit, happy and to coordinate services with my various health providers, as warranted. I acknowledge that I either have my doctor's approval to participate based on a recent physical or assume full responsibility for my health without medical approval. I acknowledge that medical referrals, recent lab values, and/or access to my health provider medical notes on subjects related to my health and nutrition may be requested to provide best services. I agree that it is my responsibility, not hers, to provide records or release records to:

Joda P. Derrickson, PhD, RDN, LD #140
Lightshine Wellness,
1521 Alexander Street, #903
jodaderr#@gmail.com
808-220-4165

___4. **Full Payment and Refunds.** I acknowledge that I am 100% responsible for all payments related to services rendered by Joda P. Derrickson, PhD, RDN and Dr. Derrickson, PhD, RDN is not able to take insurance payments. Non-payment will immediately lead to a discontinuation of services provided by Joda P. Derrickson, PhD, RDN. I also acknowledge that I am 100% responsible for rescheduling, and that Joda P. Derrickson, PhD, RD's refund policy that there are no refunds from credit cards or checks ever, only in-kind, books and other services rendered at a future time to either myself, or another person Joda P. Derrickson, PhD, RD believes she can work with. Full refunds are available with cash payments.

____ 5. **Acknowledgements of dietary, health and fitness limitations**. I acknowledge that I am purposely commencing activities that may affect my weight, nutritional status, metabolism, fitness; flexibility, strength, organization and that I willfully choose to do so. I further acknowledge that any limitations I have either been initially acknowledged in writing on Joda P. Derrickson, PhD, RD's Assessment form, or communicated clearly in person. I also acknowledge that I must constantly be mindful of my limitations and must clarify or correct suggestions or recommendations she provides that I are not consistent with my recommendations, to best make the best choices for my health.

___6. **Privacy of Personal Information Protected**. I acknowledge that Dr. Derrickson seeks to complete assure the privacy of my personal information, and to never share information about me unless I agree to release my information either in person, in writing, or any form of electronic communication. Protected information includes any personal information, contact information, medical records, lifestyle practices, names, health conditions, medications, surgeries, supplements, allergies, demographic and financial information. I further acknowledge that internet communication is never 100% private, and that Joda P. Derrickson, PhD, RDN can only provide "due diligence" by consistently providing secure forms of communication and not releasing information. I further acknowledge that if I should agree to review her services, communicate via the Internet or social media, I accept the risk of exposure it inherently provides, and not hold Joda P. Derrickson liable.

__ 6. **Waiver of Liability.** In consideration of being allowed to participate in any of the assessment, activities and educational effort provided by Joda P. Derrickson, PhD, RD I do hereby waive, release and forever discharge, her, any of her agents or representatives, of all liabilities for any illnesses, injury or other damages associated with participation in any activities overseen by Joda P. Derrickson, PhD, RDN. Furthermore, I also fully waive any liability or responsibility due to ordinary negligence or omission connected with my participation. I acknowledge this release was given voluntarily, in advance of any injury or damage, and does not apply to gross negligence or criminal conduct.

This agreement shall be binding upon the undersigned, his/her heirs, executors, administrators, and other representatives.

____________________________	______________________________________	______________
Signature	Printed first and last name	Date