



**NEW PATIENT FORMS**  
**Please print clearly**

**GENERAL INFORMATION (please complete in detail, all information is confidential)**

|  |     |                      |          |   |  |
|--|-----|----------------------|----------|---|--|
| Patient Last Name: _____   |     | First Name: _____    |          | MI: _____   |  |
| Address: _____   |     |                      |          | Number of Children: _____   |  |
| City: _____ State: _____ Zip: _____  |     |                      |          | Names & Ages: _____   |  |
| Phone (Home): _____  |     |                      |          | _____   |  |
| Email: _____   |     |                      |          | Spouse Name: _____  |  |
| Phone (Work): _____ Phone (Cell): _____  |     |                      |          | Phone: _____  |  |
| Today's Date<br>/ /  | Age | Date of Birth<br>/ / | Sex: M F | Social Security Number<br>- -   | <input type="checkbox"/> Married <input type="checkbox"/> Single<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |
| Patient Employer's Name: _____   |     |                      |          | Driver's Lic. #:  |  |
| Address: _____   |     |                      |          | <b>EMPLOYED</b>   |  |
| City: _____ State: _____ Zip: _____  |     |                      |          | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time<br><input type="checkbox"/> Retired <input type="checkbox"/> Not Employed |  |
| Phone: _____ Occupation: _____   |     |                      |          | <b>STUDENT</b>  |  |
|  |     |                      |          | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time   |  |
| <b>Referred By:</b> _____  |     |                      |          |   |  |
| If you were not referred to us, how did you hear about Alpine Wellness Chiropractic? _____ |     |                      |          |   |  |
| _____  |     |                      |          |   |  |

**Health Profile**

Dietary consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.   Weight 1 year ago: \_\_\_\_\_ lbs.   Min. Adult Weight: \_\_\_\_\_ lbs at age \_\_\_\_\_  
 Maximum Weight: \_\_\_\_\_ lbs. at age \_\_\_\_\_

Do you exercise?  Yes  No

If yes, what kind? \_\_\_\_\_

How often? \_\_\_\_\_

Have you been on a diet before?  Yes  No \_\_\_\_\_

If yes, please specify which diet and why you think it didn't work for you (e.g. too rigid, too much cooking involved, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's medically supervised weight loss method (10 being the most important): \_\_\_\_\_**



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

**Medical Information:**

Please list any physicians you see and their specialty:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diabetes:**

Do you have diabetes?  Yes  No (if no, skip to next section)

If so, are you under the care of a physician? Yes No

If so, which type?

- Type I – insulin dependent (insulin injections only)
- Type II – non-insulin dependent (diabetic pills)
- Type II – insulin dependent (diabetic pills and insulin)

Is your blood sugar level monitored? Yes No

If so, by whom? Myself Physician Other (specify):

\_\_\_\_\_

Are you taking any medication? Yes No

If so, please list:

\_\_\_\_\_

Do you tend to be hypoglycemic? Yes No

**Cardiovascular Health:**

Have you had a cardiovascular event? Yes No (if no, skip to next section)

If so, please specify:

\_\_\_\_\_

How long ago?

\_\_\_\_\_

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

\_\_\_\_\_

Do you have a history of arrhythmia Yes No

Have you ever been diagnosed with Congestive Heart Failure? Yes No

**Hypertension:**

Do you have high blood pressure? Yes No (if no, skip to next section)

If so, do you have your blood pressure checked? Yes No

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

\_\_\_\_\_

\_\_\_\_\_

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

**Kidney Health:**

Have you been diagnosed with kidney disease?  Yes  No (if no, skip to next section)

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

Have you ever had Gout?  Yes  No

Have you ever had Kidney Stones?  Yes  No

**Liver Health:**

Do you have liver problems?  Yes  No (if no, skip to next section)

If so, please specify:

\_\_\_\_\_

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**Colon Health:**

Do you have:  Irritable Bowel  Colitis  Diarrhea  Diverticulosis  Crohn's disease  
 Constipation

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**Stomach/Digestive Health:**

Do you have:  Acid Reflux  Gastric Ulcer  Heartburn  Celiac Disease

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**Ovarian/Breast Health:**

Check off the situations that apply to you currently:

- Irregular Periods     Menopause     Fibrocystic Breasts  
 Painful Periods     Hysterectomy     Heavy periods  
 Amenorrhea     Uterine fibroma     Cancer (uterus, breast)

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

Please indicate the date of your last menstrual cycle:

\_\_\_\_\_



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

**Thyroid Function:**

Do you have thyroid problems?  Yes  No (if no, skip to next section)

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**Emotional Evaluation:**

Do any of the following apply to you? (if no, skip to next section)

Depression  Anxiety  Panic Attacks

Bulimia (or history of)  Anorexia (or history of)

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**Inflammatory Conditions:**

Do any of the following apply to you? (if no, skip to next section)

Migraines  Fibromyalgia  Rheumatoid Arthritis  Lupus  Osteoarthritis

Chronic Fatigue Syndrome  Psoriasis

Other autoimmune or inflammatory condition:

\_\_\_\_\_

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

**General:**

Do you have Parkinson's disease?  Yes  No

Do you have cancer?  Yes  No

Are you in cancer remission?  Yes  No

If so, please specify and indicate for how long: \_\_\_\_\_

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list:

\_\_\_\_\_

Are you generally fatigued or have low energy?  Yes  No

Are you pregnant?  Yes  No      Are you breastfeeding?  Yes  No

Do you get cold easily?  Yes  No      Do you have cold hands/feet?  Yes  No

Do you have other health problems?  Yes  No

If so, please specify:

\_\_\_\_\_

If so, are you under the care of a physician?  Yes  No

Are you taking any other medications not listed above?  Yes  No

If so, please list:

\_\_\_\_\_



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

Are you currently taking Vitamins, Herbs or Supplements?  Yes  No

**Vitamin, Herb or Supplement Name Reason**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Allergies:**

Do you have any **food** allergies?  Yes  No

If so, please list:

\_\_\_\_\_

Do you have any **medication** allergies?  Yes  No

If so, please list:

\_\_\_\_\_

**Eating Habits:** (please be as honest as possible so that we may better help you)

**Breakfast**

Do you have **breakfast** every morning?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you have a **snack** before lunch?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

**Lunch**

Do you have **lunch** every day?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you have a **snack** before dinner?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

**Dinner**

Do you have **dinner** every day?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you eat a **snack** at night?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_

\_\_\_\_\_

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

**Other:**

Do you prefer:  Sweet foods  Salty foods  Fatty foods

Are you a vegetarian?  Yes  No

How many glasses of water do you drink per day? \_\_\_\_\_ glasses

How many cups of coffee do you drink per day? \_\_\_\_\_ cups

Do you smoke?  Yes  No

If yes, how many packs per day? \_\_\_\_\_ for how many yrs? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, what, how much, and how often? \_\_\_\_\_

**CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger**

*Score each item on a 0—10 numbering scale. Each feeling represents a different part of the brain and different neurotransmitters*

**Compulsions/Cravings**

Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

0----1----2----3----4----5----6----7----8----9----10  
 Never occurs Constant

**Appetite**

Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

0----1----2----3----4----5----6----7----8----9----10  
 Never eat more Always eat more

**Satiety**

A feeling of fullness acquired during eating. When you eat, you usually:

0----1----2----3----4----5----6----7----8----9----10  
 Leave food on plate one plate only second's thirds

**Hunger**

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

0----1----2----3----4----5----6----7----8----9----10  
 Never hungry Constant hunger

**You must take vitamins and minerals while you are on the Ideal Protein Weight-Loss Method. If you stop taking them, you may experience undesirable side effects.**

\_\_\_\_\_ (Client's initials)

**The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.**

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

**If you have health problems not indicated on this health profile, please consult your physician.**

**ABSOLUTE CONTRA-INDICATIONS**

**No potential dieter is to be placed on the Ideal Protein Weight Protocol with or without the consent of his/her primary care provider or specialist monitoring this patient.**

If these situations apply to you please notify the staff.

- Severe Liver Disease
- Severe Kidney Disease
- Congestive Heart Failure (CHF)
- Active Cancer (or in remission less than 3 years)
- Cardiac/Cardiovascular Event (within the last 6 months)
- History of unstable Arrhythmia
- Parkinson's Disease



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

## **FEE STRUCTURE**

**Please note some of our fees for your initial visit:**

|   |   |
|---|---|
| <b>Initial Consultation (1 hour)</b>                    | \$50.00   |
| <b>IP Foods Box (7 packets/Box)</b>                     | \$27.00 + \$2.17 Tax = \$29.17                        |
| <b>IP Foods Packets (Individual)</b>                    | \$4.00 + \$0.32 Tax = \$4.32                          |
| <b>Required Supplements (Multi, Potassium, Calcium)</b> | \$28.00+ \$24.00+<br>\$21.00+ \$5.88 Tax = \$78.88/mo |
| <b>Follow-up Appointments (Weekly)</b>                  | \$10.00 per week                                      |

**Minimum number of IP Foods Packets per week is 21 during Phase I.**

Please note that if you are under chiropractic care, our fee structure for those services is separate than this fee schedule.

## **FINANCIAL POLICIES**

1. All first visit charges are payable when services are rendered. If your visit is promotional or you have a gift certificate, please inform the front desk staff.
2. Payment is required at the time of service or sale.
3. ALL IDEAL PROTEIN FOOD PURCHASES ARE FINAL. NO RETURNS WILL BE ACCEPTED. If desired, unopened food may be exchanged for products of the same price. Ideal Protein foods may be used for protein supplementation outside of protocol.
4. When you receive a bill from us, payment is expected within 30 days. If you need to make payment arrangements, please contact front desk staff before the 30 day period. Failure to pay will result in the account being assigned to a collection agency.
5. There is a \$25 fee for all returned checks..
6. If payments are not received in accordance with the above guidelines, the accounts will be turned over to a collection agency. The patient will be responsible for any collection fees, attorney fees and other costs involved in referring their delinquent account to the collection agency.
7. All lab services provided outside our office are billed separately. We do not handle any of the lab billing. If you have questions or concerns about a bill from the lab you must contact them directly.
8. Orthopedic supplies, supplements, food and other retail items provided by our office are not covered by insurance and will not be billed to the insurance company (some exceptions may apply). Payment is expected at the time of purchase.

*I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Alpine Wellness Chiropractic to obtain a credit report if deemed necessary.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date



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

**Missed Appointments**

Our policy on missing appointments is simple, **YOU DON'T!!!** Sounds a bit harsh but we are serious about your health and your results. Please inform us of any possible absences prior to your scheduled time by phoning our office as soon as possible. A missed appointment takes you off your program schedule and must be rescheduled as soon as possible.

**There is a service charge of \$35.00 for missed appointments if you do not call and let us know you're not coming or if you miss your appointment time and we have to call you.**

Our missed appointment charges are donated to the International Chiropractic Pediatric Association in Pennsylvania for pediatric research. If it is a vacation that will take you off schedule, please let us know so that we can work around it as best as possible. If you are going away for longer than 2 weeks, we will do our best to recommend a clinic in your vacation spot in order to maintain your program. We would like you to know however, we love to make house calls to the Caribbean!

*I understand that if I do not call and notify AWC staff that I will be unable to make my appointment time or if I do not come at my appointed time and the staff must call me to reschedule, I will be responsible for a \$35.00 Missed Appointment charge that must be paid before receiving additional services or supplies.*

---

Patient Signature

Print name

Date



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

**MEDICAL INFORMATION RELEASE FORM**

This form will help us coordinate the exchange of information.

**Release of Information**

Patient hereby authorizes AWC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all test of any type or character of patients such persons as AWC deems appropriate.

Please provide Primary Care Physician's information:

Doctor's Name: \_\_\_\_\_

Office/ Clinic Name: \_\_\_\_\_

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

Clinic Phone Number: \_\_\_\_\_

Doctor's E-mail: \_\_\_\_\_

Specialty or scope of practice: \_\_\_\_\_

If referred by specialist please provide their information as well:

Doctor's Name: \_\_\_\_\_

Office/ Clinic Name: \_\_\_\_\_

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

Clinic Phone Number: \_\_\_\_\_

Doctor's E-mail: \_\_\_\_\_

Specialty or scope of practice: \_\_\_\_\_

(Please do not neglect to fill in your Doctor's information)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date



## Notice Of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION** We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$20.00 per hour (with a minimum of \$20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS** If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Denesa Pozner, DC. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Denesa Pozner, DC

**Alpine Wellness Chiropractic, 16205 W. 64th Ave., Ste. B-1, Arvada, CO 80007 Phone: 303.431.8558 Fax: 303.431.9232**



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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## For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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**NEW PATIENT FORMS**  
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**Informed Consent for Weight Control Program**

(Do not Sign until all your questions have been answered and you wish to begin the program)

My Name: \_\_\_\_\_

**Consent to participate**

I hereby consent to act as a participant in a weight control program involving the use of protein and other supplements. I understand that various employees of Alpine Wellness Chiropractic may provide this to me.

If I have any questions about this or need further explanations, I understand that I should speak with my medical provider.

I have been informed that the possible benefit and value of this treatment is not guaranteed. I understand that there are many alternative treatments or procedures that are appropriate and available that might be beneficial to me. Some of those alternatives or choices include but may not be limited to:

1. No treatment at all.
2. Conservative lifestyle changes.
3. Drugs.
4. Surgery.
5. Watch and wait, while reporting my condition to a physician.

I understand that I have the right not to participate in this program or to discontinue it after I have begun, for any reason whatsoever. I understand that I have the right to ask questions and to know the purpose and objectives of my treatment program.

Having read this page, I hereby consent to this program. I have had adequate time to ask any questions and understand the answers provided. At this time I have no other questions, but I am aware that any future questions may be posed and will be responded to in a timely fashion.

Dieter Name \_\_\_\_\_

Dieter Signature \_\_\_\_\_ Date \_\_\_\_\_

Weight Coach Signature \_\_\_\_\_ Date \_\_\_\_\_