

**Healthy Habitudes, LLC
The Moore Orthopaedic Clinic**

**CONSENT/
RELEASE AND WAIVER**

Participant's Full Name

Date of Birth

Social Security Number

Healthy Habitudes, LLC Nutritional Consultation
Name of Program

As the parent or legal guardian of the above named Participant, I hereby give my consent to The Moore Orthopaedic Clinic ("Moore") and Healthy Habitudes, LLC ("HH") to provide nutrition services to the Participant as part of his/her participation in the above mentioned Program and agree to all discussed fees for services rendered. Moore or HH's services may include, but may not be limited to: evaluation, follow-up and education. I grant permission to Moore's or HH's employees or contractors to provide such services to Participant as deemed necessary by Moore or HH for the design and implementation of nutritional programs.

I understand that Moore's or HH's employees or contractors providing services at the above named program are not necessarily physicians, medical doctors, or nurses. I understand that the services provided by Moore or HH relate to nutrition services, and are not intended to be medical treatments.

I hereby fully release Moore, Healthy Habitudes, and all of Moore's and Healthy Habitudes' employees or contractors, from any and all liability associated with the evaluation, training, or other health services provided to Participant as part of Participant's participation in the above named program.

Authority or Relationship of Representative
(Unless parent, attach copy of documentation of authority,
e.g., a court order designating guardianship)

Signature of Personal Representative/Guardian

Signature of Client

Date