

**Responsibility, Confidentiality and Liability Agreement for
Holistic Nutrition & Wellness Counselling Services**

Today's date _____

I, _____ (your legal name), hereby acknowledge, understand and agree to the following:

1. Stephanie Bonetta CNP, a certified nutritional practitioner, is providing me with nutritional counselling services as per my request.
2. Services can include food choices and meal plans, cooking videos or in-house cooking, health and wellness educational workshops, written protocols with supplements, herbs, oils, superfoods, yoga, meditation, pranayama, card readings and emotional/mental support, yoga, meditation and pranayama sessions, national and international yoga wellness retreats.
3. The purpose of nutritional counselling is to improve the overall health, vitality and well-being of the body through nutritional education and the use of natural foods and non-medicinal nutritional supplements. They are not recommended for the purposes of treating diseases, disorders or conditions.
4. Stephanie Bonetta is not a medical practitioner, naturopath or dietician.
5. As part of her Nutritional Counselling Services, I may be asked to provide information concerning my physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet. This information is collected to enable Stephanie Bonetta to (i) assess my knowledge of nutrition, (ii) educate me about the benefits of sound nutritional practices, and (iii) recommend dietary changes to improve my general health, vitality and overall well-being. All information shared for the purpose of this professional relationship will be held in strict confidence and will not be released or disclosed to any other person, without my prior consent, except as required by applicable law.
6. If Stephanie Bonetta suspects the existence of a disease, disorder or condition, she will inform me of this suspicion. However, I acknowledge this is NOT a diagnosis or conclusion about the state of my health and that I am directed to promptly consult a licensed Physician or Naturopath about any suspected problems.

7. If I have a disease, disorder or condition, I shall disclose this to Stephanie Bonetta during her initial intake questionnaire and consultation. If I develop said illness while in her care, it is my responsibility to disclose this information to her immediately.
8. Should I request Stephanie Bonetta to recommend dietary changes and/or nutritional supplements to enhance my body's natural ability to resist and/or overcome a known disease, disorder or condition, it is my responsibility to disclose the nature of the disease, disorder or condition and all other relevant details to her. If I have not previously consulted a licensed Physician or Naturopath about the disease, disorder or condition, I acknowledge that I am directed to promptly do so. I am not to alter or discontinue treatments prescribed by a licensed Naturopath, Physician or other licensed health professional without consulting the individual who prescribed the treatment.
9. In providing Nutritional Counselling Services to me, Stephanie Bonetta, is relying upon the truth, accuracy and completeness of all information I have provided to her. Any recommendations I follow for changes in diet, including the use of nutritional supplements, are entirely my responsibility.
10. I am ready to take full responsibility in my health and wellness journey while in Stephanie Bonetta's care. I am aware that natural health changes may require more time, patience and commitment than conventional, drug prescribed results. I am ready and willing to take the necessary steps however long they may be that can lead to a healthy, natural sustainable lifestyle.

In consideration of my participation in Stephanie Bonetta's nutritional well-being services, I hereby accept all risk to my health, including injury or death that may result from such participation and I hereby release Stephanie Bonetta, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, including my death, that may result from or occur as result of my participation in her services, whether caused by negligence or otherwise.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A FULL AND FINAL RELEASE OF ALL COSTS, CLAIMS, CAUSES OF ACTION AND DAMAGES OF ANY KIND ARISING FROM OR IN CONNECTION WITH THE NUTRITION COUNSELLING SERVICES.

I GIVE STEPHANIE BONETTA PERMISSION TO SHARE MY INFORMATION WITH MY HEALTHCARE PROVIDERS AND ANY HEALTHCARE PROVIDERS SHE DEEMS ACCEPTABLE.

_____ (Your signature)

_____ (Date signed)