CONFIDENTIALITY

NOTICE OF PRIVACY PRACTICES AND CONSENT FOR SERVICES

I, _____, hereby give consent to Nikola Hamilton to provide nutrition counseling to myself. I understand that the consult will provide information and guidance about my diet, lifestyle, and nutrition. I understand that Nikola Hamilton is a qualified nutritionist and she does not dispense medical advice, nor will she diagnose or treat any medical condition. Methods of nutritional evaluation or testing are not intended to substitute diagnosis, treatment or care of disease by a medical provider. Rather, these assessments are intended as a guide for enhancing my nutritional health and monitoring my progress towards achieving my goals.

I agree to hold Nikola Hamilton, MSc harmless for claims or damages in connection with our work together. This is a contract between myself and Nikola Hamilton, MSc and I understand that it is also a release of potential liability.

I acknowledge and take full responsibility for my life and well-being, as well as the lives and well-being of my family and children (where applicable), and all decisions made during and after the duration of my nutrition sessions. I expressly assume the risks of nutrition sessions, including the risks of trying new foods and the risks inherent in making lifestyle changes. I release Nikola Hamilton, MSc from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in lay or equity, which I ever had, now have or will have in the future against Nikola Hamilton, MSc, arising from my past or future participation in, or otherwise with respect to, the nutrition sessions, unless arising from the gross negligence of the Nutritionist, Nikola Hamilton, MSc.

Further, if I would like nutritional advice provided through web-supported platforms (including but not limited to Whereby, Skype, Google Hangouts, and FaceTime) I understand and accept that Internet associated activities are inherently at risk for a breach of personal information. I understand that if I schedule a web-based session that this implies consent and understanding of these risks.

OUR PLEDGE TO YOU

In order to provide quality care and to comply with legal requirements, we create a record of the services you receive. We understand that health/nutrition information about you is personal and we are committed to protecting this information. Medical records, personal information, and history divulged in session to Nikola Hamilton, MSc will be kept strictly confidential unless the client consents to sharing medical and/or nutrition information by way of a signed release.

OTHER USES OF MEDICAL INFORMATION

We will ask you for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING NUTRITION/WELLNESS INFORMATION ABOUT YOU

In most cases, you have the right to look at or get a copy of nutrition/wellness information when you submit a written request. We will process your request within 10 days of receipt of your request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if that is not part of the health information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to restrict the use of your health information for use in research.

If you signed this note electronically, you have the right to request and receive a paper copy.

PAYMENT

Payments are due at the time of service. Prices can be found at https://www.beatifylife.com/services

Cash, Venmo, or checks are accepted. There are no refunds for payments made to Nikola Hamilton, MSc or Beatify.

CANCELLATION POLICY

I understand that I must provide 24 hours notice of cancellation or rescheduling. I understand that failure to show, or cancellation with less than 24 hours notice, will result in a charge of 50% of the service price.

I acknowledge that I have read, or have had read to me, the above consent.

Name:_____ Signature: _____

Date of Birth: _____ Date: _____

Email Address: _____ Address_____

Phone Number: _____ _____

❒ Nikola Hamilton, MSc is interested in conducting research to identify the relationship between nutrition and health. *By ticking this box, I allow my data to be used for research purposes.* ***Should I consent, all personal identifiable information will be removed.***

If you agree, please read and sign the attached "Consent Form Addendum"

CONSENT FORM ADDENDUM

AUTHORIZATION (CONSENT) TO PERMIT THE USE OF NUTRITION AND PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

Why is my additional consent being requested?

Through the use of this additional consent form form, we are seeking your authorization (consent) for the use and disclosure of your nutrition and medical information for the purpose of future research studies.

Personal identifiers will be removed from the identifiable private information and stored in a secure database. After such removal, your information could be used for future research studies, or distributed to another investigator for future research, without additional informed consent from the subject or legally authorized representative.

Name of Principal Investigator: Nikola Hamilton, MSc
Purpose of Research: To investigate the relationship between diet, nutrition services, well-being, health, and longevity.

This Informed Consent Form has two parts:

- Patient Information Sheet (to share information about the research with you)
- Certificate of Consent (for signatures if you agree to take part)

PART I: Patient Information Sheet

Introduction
We are attempting to better understand how nutrition and nutrition counseling affects overall health, longevity, wellness, athleticism, and disease. Of particular interest is the influence that dietary intake may have on overall health. We are asking to use the information you provide throughout your nutrition services with Nikola Hamilton, MSc for this research. This consent form allows you to decide whether or not you would like to participate. Participation is not mandatory. Before signing, please read the entire document carefully and take the time to contemplate whether or not you would like to participate. You may email Nikola Hamilton, MSc at any time with questions at beatifylife@gmail.com.

Every participant should understand:

1. Participation is voluntary. If you chose to participate you can withdraw at any time. There will be no penalty for withdrawing.
2. Because data will be anonymized, it may be impossible to remove data once it is collated.
3. Regardless of whether or not you participate, it will not affect the services you receive from Nikola Hamilton, now or in the future.
4. Your identifying information (name, contact information, etc.) will be completely anonymized. Identifying information will never be printed or published in any form.

The purpose of data collection and future studies:
The purpose of collecting your data for future studies is to analyze any relationships between nutrition services, diet, and health.

Participant selection:
We are inviting all clients who receive nutrition services from Nikola Hamilton, MSc to participate in this research.

What is involved?
If you agree to participate we will ask you to sign this form. We may also analyze information regarding your health history and diet that has been collected throughout your services with Nikola Hamilton, MSc. This may include therapy

notes, dietary intake, nutrition questionnaires, medical history (if shared with nutritionist), medical procedures, test results, family history, and medicines you take.

We will anonymize your information and store it in a database, alongside other patients who take part in this research. There is no limit to the amount of time we will keep this anonymized data.

What are the potential benefits of participating?
You will not benefit directly from these research studies. Knowledge gained from this research may help researchers, physicians, and nutritionists understand diet, health, and the role of nutrition services.

Are there any costs involved?
There are no costs involved in this study. It is free to participate. You will not be reimbursed for participation. If this project leads to new drugs, tests, or other products, you will not share in the profits.

Are there any risks involved?
Data collection is not intended to involve sensitive information and no physical harm can result from participation. You may withdraw from the research at any time. Your services will not change as a result.

How will the information remain private?
Your privacy is of utmost importance to us. Below are the steps we will take to ensure confidentiality.

- We will compile any relevant health and/or nutrition information in a secure database. We will then delete all identifiers, including your name, and replace this with a code number.
- Only those involved with the research projects will have access to this database.
- We will not provide your identifying information to anyone.

Who will have access to my identifiable medical record information related to my participation in this research study?

Nikola Hamilton, MSc and their research staff will or may have access to your identifiable medical record information related to your participation in this research study.

In unusual cases, the investigators may be required to release your identifiable research information (which may include your identifiable medical record information) in response to an order from a court of law. If the investigators learn that you or someone with whom you are involved is in serious danger or potential harm, they will need to inform, as required by law, the appropriate agencies.

What uses of my identifiable medical record information will this research study involve?

This research study will involve the recording of current and/or future nutrition and medical information from your hospital and/or other health care provider (e.g., physician office) records. The information that will be recorded will be limited to information concerning how diet/nutrition are related to your health. This information will be used for the purpose of research to help identify ways in which diet may play an integral role in health, longevity, and/or disease prevention and treatment.

For how long will the investigators be permitted to use my identifiable medical record information?

The investigators may continue to use and disclose your identifiable medical record information for the purposes described above for an indefinite period of time.

What are my options?
This is an optional study. You are not required to participate in it. If you decide to participate you may change your mind and withdraw at any time.

How will I know the results of this study?
Upon completion, you will be contacted with information about where to find the study results. The research may be publicized (without any identifying information) so that others may learn from the findings.

I have more questions – who should I ask?
If you have any questions (regarding the study or your rights as a participant) we are happy to talk to you. Please email Nikola Hamilton at beatifylife@gmail.com.

PART II: Certificate of Consent

Name of Principal Investigator: Nikola Hamilton, MSc
Purpose of Future Studies: To investigate the relationship between diet, nutrition services, well-being, health, and longevity.

I have read the above information (or have had it read to me).	Yes	❒	No	❒
I have had the opportunity to ask any questions (and believe that questions were answered sufficiently, when applicable).	Yes	❒	No	❒
I understand that I may withdraw from this study at any time, and do not need to provide justification for this.	Yes	❒	No	❒
I understand that all data will be anonymised and that removing data, after collation, may therefore be impossible.	Yes	❒	No	❒
Upon study completion, I would like to be notified of the study results.	Yes	❒	No	❒
I voluntarily consent to participating in future research studies..	Yes	❒	No	❒
I understand that anonymized data will be stored indefinitely. *(No identifying information will be archived.)* I consent to my anonymized data being used for future studies.	Yes	❒	No	❒

By signing this form, I agree to allow the continued use and disclosure of my identifiable medical record information for the purposes described above. A copy of this authorization form will be given to me.

Print Name of Participant _____

Signature of Participant _____

Date _____
Month/day/year