



"Transform Your Health, Transform Your Life"
Jo Panyko, B.S., Master Nutrition Therapist
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Business Client Agreement and Release

I, the undersigned, agree to accept and pay for nutritional consultation services offered to me by **Chrysalis Nutrition and Health, LLC** as discussed below:

Missed appointments: No-shows will be billed at the hourly rate. Please provide at least 24 hours' notice if an appointment needs to be re-scheduled due to illness or emergency.

Late for appointments: Please let me know at least one-hour before if you will be late to your appointment. If not, an appointment you are late for will end at its regularly-scheduled time, regardless of when it begins, unless due to an emergency wherein I will try to re-schedule with you.

Payment options: Payment for a single appointment is due at the time of service. Payment is due for the 3-session Nutrition Starter Package when the Introductory Packet is returned to me and for the Transformational Tri-Package at the time of scheduling the first meeting in the series. Payment for individual Metamorphosis Meetings is due at the time of service. Payment for supplements, testing or other items are due at the time of purchase. Payment for groups is due at the time of booking. Payment options include cash and personal checks at this time. Please check with your insurance provider to determine if your insurance covers my services or you may be able to deduct my fees from an HSA (health savings account). I'd be happy to give you an invoice for documentation. MasterCard/Visa credit/debit cards will be an option in the near-future. There is a \$50 fee for all returned checks.

I, the person signed below, understand that although covered by professional liability insurance, Jo Panyko is recognized by the State of Colorado as a complementary and alternative health care practitioner and is not licensed, certified or registered by the State as a health care professional. I also understand that nutritional counseling services are educational in nature and may include, but may not be necessarily limited to: food, eating-habit and supplement guidance; special dietary plans; diet analysis; menu plans and shopping lists; sleep, general exercise and relaxation suggestions; detoxification plan; healthy home and workplace awareness; attitudinal and behavioral modification suggestions; lab test reviews based on established functional medicine ranges for nutritional evaluation; blood/saliva/urine/stool-test suggestions; and client handouts/supportive technical information. Further, I acknowledge and understand that the counseling services under this Agreement and Release are intended to balance and support the body and are not intended as diagnosis, treatment, prescription or cure for any physical or mental disease, nor are they intended as a substitute for regular medical care. Nothing said, written or implied should be construed as medical advice for any given medical condition. I agree that I have been advised to discuss the recommendations with my physician.

I agree that this Client Agreement and Release is being signed voluntarily and not under duress of any kind. I agree that I fully understand and accept the above information and have asked for clarification of any information. I also agree that I have disclosed all known medical conditions, have answered all questions honestly and to the best of my ability, and will keep the practitioner advised of any changes in my health status and treatments. I further acknowledge that I have received a copy of this Agreement and Release for my records.

Print Name: _____

Signature: _____ Date: _____