

**AN APPLE A DAY HEALTH CARE SOLUTIONS, LLC
CLIENT INFORMED CONSENT/WAIVER FORM**

I, _____, understand that the services provided to me by Kelly Karpa, PhD, RPh are limited to those normally provided by pharmacists in providing drug related information for both prescription and over-the-counter products including nutritional supplements and/or complementary/alternative medications.

I further understand that the information/services provided to me by Kelly Karpa are not intended to diagnose any medical condition, prescribe any medication for me, change my medications in any way, or treat any physical/mental condition. I understand that my conversation/session with her is not a substitute for a medical examination by a physician. Information provided by her is strictly educational in nature and I am encouraged to discuss any and all information discussed today with my physician or health care provider. I understand that Kelly Karpa is not a medical doctor; her training is in pharmacology.

Kelly Karpa may explain to me the pharmacology or science of the drugs that I am currently taking (which may include but is not limited to the mechanisms of those drugs, the properties of those drugs, adverse effects associated with those drugs, and/or drug interactions.)

In the course of our conversation/session, Kelly Karpa may also discuss over-the-counter medications or supplements, some of which I may be able to purchase directly from An Apple A Day Health Care Solutions, LLC. Information provided by Kelly Karpa should be discussed with my physician/health care provider. I understand it is my responsibility to fully discuss this information with my physician/health care provider before acting on it. By signing this form, I agree to discuss all therapeutic recommendations made by Kelly Karpa with my physician or health care provider. If, with my physician's consent, I decide to utilize any supplements discussed with and/or provided by Kelly Karpa, and in the unlikely event that an adverse event occurs as a result of those supplements, I hereby agree to release, waive and discharge An Apple A Day Health Services Solutions, LLC and Kelly Karpa from any and all claims, damages and/or causes of actions I or any of my heirs or next of kin might have on account of any injury I may sustain as a result of the use of supplements discussed with and/or provided by Kelly Karpa.

I have informed Kelly Karpa of all of my known medical conditions and medications/supplements that I am currently taking. I have answered all questions honestly and completely. I agree to keep Kelly Karpa updated to any changes in my health status including any changes to my medications.

I, _____, have carefully read this form and fully understand its meaning and agree to the content of this form in full. All of my questions regarding information and/or supplements provided by Kelly Karpa have been answered to my complete satisfaction. I, therefore, accept pharmacotherapeutic counseling on this basis.

(signature)

(date)

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive pharmacotherapeutic care.

(signature)

(date)