

## Ideal Protein Slidell Policies for Weight Loss Success

Please initial to indicate that you are aware of these important policies:

\_\_\_\_\_ 1. I understand and agree that while on Phase 1 of the Ideal Protein protocol, I will purchase at least 21 individual Ideal Protein products per week from this clinic. I can buy more than that, but the average will be no fewer than 21 items per week.

\_\_\_\_\_ 2. I understand and agree that I must purchase from this clinic and take the required Ideal Protein supplements as scheduled and outlined in the Phase 1-3 protocols. A well-planned, low carb diet results in the loss or increased need of certain key nutrients. The IP supplements are of the highest quality and importance to the dieter's success.

\_\_\_\_\_ 3. I understand that my food order is to be placed no later than 48 hours before my appointment time. I understand that if my food order is not placed in time this will impact not only my coaching session but that of the person following me. I may have to come back to pick up my order at a later time.

\_\_\_\_\_ 4. I understand and agree that I will keep a daily food journal and bring it to all weekly check-in visits. I understand that if I fail to bring my journal to my appointment more than once, my coach will need to reschedule my appointment. I understand that this is a mandatory requirement designed to optimize my results.

\_\_\_\_\_ 5. I understand that drinking alcohol of any type while on this diet can be extremely dangerous. It can cause my blood sugar to drop suddenly and cause me to pass out. This can result in injury or be fatal. I agree to abstain from all alcohol while on this diet. I understand that if I drink alcohol while on the program, I will need to be discontinued from the program.

\_\_\_\_\_ 6. I understand that if I am on ANY form of birth control, I must use a "back-up" method of birth control. While metabolizing fat, hormones are released, which can make hormonal forms of birth control less effective.

\_\_\_\_\_ 7. I understand that my short term and long term success will be severely affected if I deviate from the program. I also understand that if I repeatedly deviate from the program, my participation will be terminated by the clinic.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_