[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Dear [Patient Name],

Welcome to the [Program Name] Premium Medical Nutrition Program. We are pleased to have you join our specialized service designed to optimize your health through clinical nutrition and personalized care.

As a premium member, you now have access to the following benefits:

- One-on-one consultations with a Registered Dietitian
- Customized medical meal plans tailored to your health goals
- Priority scheduling and direct messaging with your care team
- Monthly metabolic health tracking and body composition analysis

**Your Next Steps:**

Your initial assessment is scheduled for **[Date]** at **[Time]**. Please complete the attached medical history and nutrition intake forms at least 24 hours prior to your appointment.

If you have any immediate questions, please contact our concierge desk at [Phone Number] or email us at [Email Address].

We look forward to supporting you on your journey to better health.

Sincerely,

[Signature]
[Name of Program Director/Lead Dietitian]
[Clinic/Facility Name]