Tucker Wellness Center
4005 Winder Highway, Flowery Branch, GA 30542

PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the health practitioners at Tucker Wellness Center to perform a Chiropractic Exam and Nutrition Response Testing health analysis, and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, chiropractic adjustments, etc. in order to assist me in improving my health, **and not the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Chiropractic and Nutrition Response Testing are not methods for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Chiropractic or Nutrition

Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____ Referred by: _____

Name: _____ Date of Birth: _____ Age: ____

Address: _____

City: _____ State: _____ Zip: _____

Home (_____)_____ - _____ Cell: (_____)_____-_____

Emergency Contact: _____ Emergency Phone: _____

Medications/ Supplements: _____

Allergies (Medications, Foods): _____

Signed: _____

(If minor, signature of parent or guardian required)

E-mail: _____

Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are missed or cancelled with less than 24 hours notification will be subject to a $40.00 cancellation fee.

The cancellation fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waved.

Our practice firmly believes that good physician / patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this cancellation policy.

_____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative **Date**