

ABC Family Chiropractic and Wellness

366 Massachusetts Ave., Suite 103, Arlington, MA 02474

PERMISSION AND AUTHORIZATION FORM REGARDING THE USE OF NUTRITIONAL RESPONSE TESTING

Please read before signing:

I specifically authorize ABC Family Chiropractic and Wellness to use a Nutrition Response Testing™ health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for 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 this is not a method 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 this testing or any natural health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body’s natural organ responses 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: _____

Print Name: _____

Address: _____

City: _____ **State** _____ **Zip** _____

Phone: _____

Signed: _____

(If minor, signature of parent or guardian is required)

Witness: _____