AGREEMENT TO DO A "NUTRITION RESPONSE TESTING™" PROGRAM

I specifically authorize Breakthrough Healthcare 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 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 understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

WAIVER OF LIABILITY TO DECLINE DOING A "NUTRITION RESPONSE TESTING™" PROGRAM

I understand that my health status is significantly diminished. It has been thoroughly explained to me by Breakthrough Healthcare why I should do a nutritional program in order to improve my health. I hereby state that I am of sound mind and I am making a conscious decision to DECLINE care. I will not Breakthrough Healthcare or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Breakthrough Healthcare from any liability regarding my health matters.
I have read and understand the foregoing.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

NOT A "NUTRITIONAL CASE" WAIVER OF LIABILITY

I understand that my health status is declining. I have been encouraged by Haas Chiropractic & Nutrition Center to seek medical attention for my health issues. I understand that doing a program at Haas Chiropractic & Nutrition Center would not successfully address my current health situation. I will not hold Haas Chiropractic & Nutrition Center or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Haas Chiropractic & Nutrition Center from any liability regarding my health matters.
I have read and understand the foregoing.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE