balanced 4 life

Payment of Services: You are responsible for the payment of the normal and necessary fees associated with the BioScan Assessment and services performed as a result of that testing, if purchased in this clinic.

I have read and understand the above information about the BioScan and my rights and responsibilities and hereby consent to the use of the BioScan. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Patient's Printed Name: _____

Signature: _____

Date: _____

IF YOU ARE UNDER 18 YEARS OF AGE, WHO ARE YOUR LEGAL PARENTS OR GUARDIAN?

Parent/Guardian: _____

Signature of Parent or Guardian: _____

Date: _____