



Sunnyside Health Center & Chiropractic Clinic, PC

Build A Better You Authorization for Services

Name: _____ Date of birth: ___/___/___ Gender: ___ Weight: ___lb Height: _____ in.

Address: _____ SS# _____

City: _____ State: _____ Country: _____ Zip/Postal Code: _____

Check here if this is a change of address Best time to reach you: _____

Phone: _____ Cell: _____ E-Mail _____

Referred by _____ Their Phone # _____

I hereby authorize Sunnyside Health Center to furnish information concerning my laboratory tests and health questionnaire for my own information. I understand that the analysis performed by Sunnyside Health Center for the ***Build A Better You*** program is an experimental procedure and not a medically recognized technique of determining disease or wellness. Any suggestions made are for my own personal use and not applicable to anyone else. I accept all responsibility for my health and do not expect any particular benefit beyond that of better nutritional awareness. Sunnyside Health Center has not guaranteed any specific results.

I understand that my ***Build A Better You*** report cannot be processed without current copies of the ***Lifestyle and Symptom Questionnaire, the 7-Day Diet Summary, and Supplement List***. The forms must be completed and sent to Sunnyside Health Center.

I give permission for Sunnyside Health Center to use my data, without disclosing my identity, for research purposes.

I understand that as part of the ***Build A Better You*** report and evaluation process, I am to receive two (2) consultations with Dr. Brouse. I understand that I must schedule the report consultation and one-month follow-up consultation within one month from the time I receive my report. Time is of the essence. If I do not use my consultation within the month, I understand that I have forfeited the consultations included in this program. Any additional time spent in the consultation or any other consultation that I may have will be charged at the regular rate.

I understand that payment must be received at the time my report is completed. I understand that I am personally responsible for all charges incurred at Sunnyside Health Center. Should collection become necessary, I will assume responsibility for any and all collections fees, court costs, and attorneys fees involved. Outstanding balances will be charged a 2% monthly interest rate (24% APR). Checks that can not be cashed (due to stop payment, non-sufficient Funds, etc.) will be charged a fee up to \$25 per check.

Signature: _____ Date: _____

Method of Payment: Visa MasterCard American Express Check Money Order