Patient Name: ______________________________________ Date: __________

System Includes:

Please initial that you understand what is included in this program:

_______ Initial **30 – 45 minute consultation** with Dr. James

_______ **Food Testing = 95 Foods Tested**

_______ **Master Food List** (Customized Based on Blood Work)

_______ The **Official TriWell Manual** – (Procedure Manual / Journal / Log Book to Track Food & Results)

_______ **Weekly video conferencing appointments** with Dr. James to go over your results for that week (**6 total appointments**).

_______ **Personalized Workout Program** with video consultation from Jacob Tucker

_______ **Staff Support** and **Accountability**

Grand Total: $ ____________

_______ **Payments Of: $** _______________

TriWell™ Consent Form / Guidelines

I, ______________________________________ accept the care plan the Doctor has laid out for me and will abide by clinic rules & guidelines to get the maximum health benefit TriWellTM has to offer me.

Credit Card # (if making multiple payments): ______________________________________
Exp. ____________ CSV: __________

____ _______________
Patient Signature: Date:

- I understand that results can and will vary from patient to patient depending on age, gender, compliance and toxicity level.
- I understand that any supplements that Dr. James recommends are NOT designed as a weight loss supplement. His recommendations are based on overall health and it is up to me whether or not I choose to purchase these supplements.
- I understand that payment is due / arrangements have been made on day 1, prior to food sensitivity testing being performed and prior to receiving supplements & supporting books / resources. I understand that all sales are final.
- Please call within 24 hours to reschedule any follow-up visits. I understand if I don't give a 24-hour notice that the scheduled visit may be forfeited.
- I understand that health insurance does NOT cover weight loss or any other cosmetic procedure we may perform.

I Have Read And Signed The New Patient Consent Form & I Accept The Terms Of This Agreement

____ ________________
Patient Signature Date

____ ________________
Clinic Director Signature Date