TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both doctor and patient to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it; nor do we offer advice regarding treatment prescribed by others. Therefore, you understand that seeking advice from another type of health care provider should not interfere with the vertebral subluxation corrective care provided by this office.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation

I,__________________________ have read and fully understand the above statements.
PRINT NAME

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

X____________________________ X________________________________
SIGNATURE **DATE**

PREGNANCY RELEASE

This is to certify, to the best of my knowledge, that I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

X___________________________ X_________________________________
SIGNATURE **DATE OF LAST MENSTRUAL(CYCLE)**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, ______________________________ being the parent or legal guardian of ____________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X______________________________ X________________________________
SIGNATURE DATE