Terms of Acceptance

Care in this office is limited to a single goal: The detection and correction of spinal nerve interference called ***vertebral subluxation***.

Specifically, a vertebral subluxation is a misalignment of one or more of the 24 movable segments in the spine which causes an alteration of nerve function. This misalignment interferes in the transmission of mental impulses between the brain and (some or all of) the tissues, organs, glands and cells that are controlled by that nerve. The end result is a lessening of the body's inborn ability to express its maximum potential for both health and performance.

The method employed for correction of vertebral subluxation is called a ***Chiropractic adjustment***. In this office, an adjustment is defined as the very specific application of a gentle force to assist the body in correcting a misalignment of a spinal bone.

We do not offer to diagnose or treat any disease or condition. If, however, during the course of your spinal examination non-Chiropractic or unusual findings are noted, you will be advised. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or condition is called, we do not offer to treat it, nor will we offer advice regarding any treatment prescribed by others.

As medical conditions are not diagnosed or treated, *health insurance policies do not typically cover the services in this office*. For the same reason, we cannot participate in workers' compensation, personal injury or complete disability forms, prescriptions, or referrals.

Our only objective is to detect and correct vertebral subluxation in order to eliminate a major interference to the expression of the innate wisdom of the body.

I understand that education about my body is an integral part of care in this office.
Therefore, I agree to a Chiropractic Orientation as a condition of my acceptance. _____
(Initials)

Please circle the Orientation time that is best for you: Monday at 6:30 pm or Thursday at 11:30 am

I, therefore, accept chiropractic care in this office.

_____
Name (please print)

_____ _____
Signature of Practice Member (or parent, if minor) Date