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Terms of Acceptance

When we accept you as a patient it's important that you understand the objectives of our care. Chiropractors provide a unique service that other healthcare providers do not offer. Chiropractors specialize in the location and correction of vertebral Subluxations for the purpose of improving the health and function of your spine and nervous system.

A Vertebral Subluxation is a misalignment or distortion of your spinal column and/or related structures that can affect your health and overall body functioning. Chiropractors spend years studying how to locate and correct this destructive condition. The correction is performed using specialized techniques called "chiropractic or spinal adjustments" over a period of time. When your spine is free of the nerve and musculoskeletal stress caused by subluxations your body can function more efficiently and your body's natural ability to heal can work more optimally.

It is not our objective to medically diagnosis or treat any disease, symptom or condition. If you desire diagnosis or treatment for a specific symptom or treatment of a specific symptom, disease or condition or advice on taking or stopping medications, we recommend you consult a healthcare provider who specializes in that area.

If we discover unusual findings during the course of our chiropractic examination(s) we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We will cooperate with you and them in your goals.

Summary - The purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery or prescribe medications but rather to improve the health and function of your spine and nerve system to help your body function at its optimum health and healing potential.

It is our sole objective to improve and maintain the health and normal function of your spine and the nerve system to the maximum degree possible for you. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

Complete if patient is a minor child.

(PRINT CHILD'S NAME)

I, _____ being the parent or legal guardian of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)