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When a patient seeks chiropractic health care and I accept a patient for such care, it is essential for us both to work for the same objective. When a patient understands the objective and the method used to attain the objective disappointment and confusion are avoided.

I do not offer to treat or diagnose any disease. I only offer to diagnose vertebral subluxations and neuromusculoskeletal conditions associated with your subluxations. The objective of chiropractic care is to eliminate a major interference (a subluxation) to the expression of the body's innate wisdom. The method chiropractic uses to correct vertebral subluxations is specific adjusting.

If in the process of chiropractic examination non-chiropractic or unusual findings are encountered, you will be advised to seek the services of another health care provider. You also may seek the advice of another health professional prior to initiating chiropractic care. Because the objective is to eliminate interference rather than treat disease, a patient sometimes becomes worse before getting better. This is the concept of retracing.

The following definitions will be helpful in understanding the preceding:

Adjustment: A chiropractic adjustment is the specific application of forces, to the spine, to facilitate the body's correction of vertebral subluxation.

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

Vertebral Subluxation: A misalignment of one or more of the 24 spinal vertebra in the spinal column which causes an 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.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives regarding my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signed: _____ Date: _____

SIGNATURE ON FILE

___ I authorize use of this form on all of my insurance submissions.

___ I authorize release of information to all my Insurance Companies.

___ I authorize my doctor to act as my agent in helping me to obtain payment from my insurance companies, and I authorize payment directly to my doctor

___ I permit a copy of this authorization to be used in place of the original.

Name (Please Print) _____

Signature _____ Date _____

