

# ***TERMS OF ACCEPTANCE AND CONSENT FOR CARE***

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

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

At Advanced Healthcare/Allied health Professionals, we have only one goal with the chiropractic care provided. It is important for each patient to understand this goal and the method used to attain it. This will prevent confusion and disappointment.

“Vertebral subluxations” are mechanical interference by the spinal bones to the normal flow of impulses traveling over the nerve pathways. Our goal is to locate, analyze, and correct these vertebral subluxations.

The chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to reduce vertebral subluxations, thereby allowing the healing properties of the body to work at maximum efficiency.

With a proper nerve supply restored through chiropractic adjustments, the body can begin the healing process of repair leading to health. In some patients this happens quickly, in others, more slowly. In some patients the repair and maintenance is complete, in others only partially completed. **WE DO NOT GUARANTEE A CURE FOR ANY CONDITION.**

**WE DO NOT OFFER TO DIAGNOSE** or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the advice of a healthcare provider that 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. **OUR ONLY GOAL IS TO ALLOW THE BODY TO PERFORM ITS JOB.** Our only method is the spinal adjustments for vertebral subluxations.

I hereby request and consent to the performance of chiropractic procedures on me (or the patient named below for whom I am legally responsible). I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interest.

I have read or have had read to me, the above consent. I have had the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and /or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I \_\_\_\_\_ have read and fully understand the above statements. All questions pertaining to my care  
(Print Name)

in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis. \_\_\_\_\_  
(Signature) (Date)

Complete if patient is a minor:

\_\_\_\_\_  
(Print child's name)

I, \_\_\_\_\_ being the legal guardian or parent of the aforementioned child have read and understand  
(Print Parent/ Guardian Name)

the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
(Signature) (Date)