Terms for Acceptance of Care at Restoration Health Chiropractic

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic & rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 is by specific adjustments of the spine.

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 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 a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Restoration Health Chiropractic for x-ray, is for examination only and they will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Restoration Health Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, spinal adjustments and other chiropractic procedures, various modes of physical and diagnostic x-rays or any other procedure that is advisable, and necessary for my condition.

Furthermore, I authorize and agree to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

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, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ___________________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover

the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature_______________________________________ (If under 18 parent's signature) Date_________________

Pregnancy Release:

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

Date of last menstrual cycle: _______________

Signature: __________________________ Date: ___________________

Consent to X-ray:

I hereby grant Restoration Health Chiropractic permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation and not to diagnose or treat any other disease or condition.

Signature (parent of minor):____ Date: _____________________________

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.

Signature: _______________________________________ Date: ___________________________

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or workers compensation case that is active or that has not been closed and finalized.

Signature: ______________________________________ Date: ________________________