COLANDO CHIROPRACTIC CLINIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for **both** to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of gentle forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity; wholeness, in which all organs, tissues and cells are functioning at 100%.

Vertebral Subluxation: A disruption in the normal flow of Life Energy in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt). We do not offer to diagnose or treat any disease or condition other than **vertebral subluxation**. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who 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 PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct **vertebral subluxations.**

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

I understand and agree that the health and accident insurance policies are an arrangement between me (patient) and the insurance company. I will authorize and assist the doctor's office in the preparation of the necessary reports and forms in order to obtain payment from my insurance company. I hereby give permission to Colando Chiropractic Clinic to contact the necessary entities and obtain benefit information on my behalf. I understand and agree that services rendered to me will be charged directly to me and that I am personally responsible for payment of same. I further understand and agree that if I fail to pay for services rendered, I will be responsible for payment of any and all costs of collection including reasonable attorney fees. I also understand and agree that if I suspend or terminate my care and treatment; all fees for professional services will be immediately due. I understand and agree that the amount paid the doctor for x-rays is for examination only and that the x-ray negatives remain the property of the doctor's office. Upon signing this agreement I am consenting to the duplication of my identification and insurance information for my patient file.

*** Please check if you are here for any of the following: ____ Car Accident ____ Work Injury ____ Other Injury

Payment is expected at the time of service unless other arrangements are made by the office.

I will be paying today by: Cash_____ Check_____ Credit Card_____

Credit Card #:_____ Exp Date:_____ Card Type:_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

_____ _____

(Signature) (Date)