Life Family Chiropractic, LLC

501 N. Knik Street
Wasilla, AK 99654
907-373-4325

TERMS OF ACCEPTANCE

When a patient seeks chiropractic 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 forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by the specific adjustments of the spine.
- **HEALTH:** A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.
- **VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and the interference to the transmission of mental impulses, resulting in a lessening of the body's innate expression of its maximum health potential.

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 expression of the body's innate wisdom. Our only method is the 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.

_____ _____

Patient Signature: Date:

CONSENT FOR MINOR CHILD

I, _____, parent and/or guardian of _____, give Life Family Chiropractic, LLC permission to care for my minor child. I understand that the above terms of acceptance apply to the minor, and I fully agree with the course of treatment. By signing this acceptance, I also agree to allow LFC to treat my child in the event that I am not able to attend an office visit with the child, however, understand that there will be times that my attendance is needed.

_____ _____

Parent Signature: Date: