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 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 wellbeing, 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 pulses, resulting in lessening the body's innate ability to express 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 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 PURPOSE 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.
(Please Print)

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 on this basis.

Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Commerce Chiropractic Clinic's "Notices of Privacy Practices" has been provided to me. I understand I have the right to review Commerce Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Commerce Chiropractic Clinic. The Notice of Privacy Practices for Commerce Chiropractic Clinic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Commerce Chiropractic Clinic's duties with respect to protected health information. I give permission to Commerce Chiropractic Clinic to use my name, address, phone number, date of birth and social security number to contact my insurance company to verify my coverage and benefits and to check the status of my insurance claims. Commerce Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a re vised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority