CARTER FAMILY CHIROPRACTIC

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Terms of Acceptance/Consent to Treat
When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward 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 and disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

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 it maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of Vertebral Subluxation.

Potential Risks: The risk of injury or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprain/strain, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, and dislocations.

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 on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I,_____, have read and fully understand the above statement. I have also had the opportunity to ask questions and all of the questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek.

Patient Signature_____ Date_____

Consent to evaluate and adjust a minor child (for treatment of a child less than 18 years).

I,_____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grand permission for my child to receive chiropractic care.

Parent Signature_____ Date_____

POLICIES
All payments are due when services are rendered unless other arrangements have been made.

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. I understand Dr. Carter's will prepare all necessary reports and forms to assist in making collections from the insurance company and that any amount authorized be paid directly to Dr. Carter's will be credited my account upon receipts. However, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if action becomes necessary to collect on this account.
Patient Signature_____ Date_____
Guardian Signature Authorizing Care_____ Date_____