TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties 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.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a decrease of the body's ability to express maximum health and function.

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 evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire 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 physical irritations from your spinal nervous system. Our only method is specific adjusting to correct vertebral subluxations.

I, **X**_____ 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/Guardian's Signature **X**_____Date:_____

PATIENT AND DOCTOR AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wilks Chiropractic will prepare all necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Wilks Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all 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 care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize Dr. Wilks to treat my condition, as he deems appropriate through adjusting my spinal column. I understand and agree that the amount paid to Wilks Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of Wilks Chiropractic, being on file where they may be seen by me at any time while I am a patient of this office. I also agree that I am responsible for all bills incurred at this office. Dr. Wilks will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient/Guardian's Signature: **X**_____Date: _____