TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and is accepted as a patient for such care, it is essential for both parties to be working toward the same objectives and understand the methods used in treatment. This will prevent any confusion or disappointment.

Adjustment:	An adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. 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.
Vertebral Subluxation:	Also known as spinal nerve interference; 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. This results in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any condition other than vertebral subluxations. 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 another healthcare provider.

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.

By signing below I acknowledge that I have read and fully understand the above statements.

_____ _____ _____

Patient Name (Printed) Signature Date

(If under 18 years of age, must be signature of parent or guardian)

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am responsible for payment of all fees charged by this office.

Signature _____ Date _____

(Must be signature of parent or guardian)

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and that Dr. Kroes and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____ (May be approximated if exact dates are unsure)

Signature _____ Date_____

(If under 18 years of age, must be signature of parent or guardian)