ARBOR WEST CHIROPRACTIC CENTER

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Mark J. Tobias, D.C., DIRECTOR

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.

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, resulting in a lessening of 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 spinal examination, we encounter no-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 the 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 subluxation.

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.

_____ _____
Signature Date

Consent to evaluate and adjust a minor child.

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

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Dr. Tobias has 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 _____.

_____ _____
Signature Date