

Health First Chiropractic Clinic Palmer Specific Chiropractic

Thank you for choosing Health First Chiropractic. We appreciate your trust and confidence in us. Our **Purpose** is "To educate and adjust as many families as possible toward optimal health through natural chiropractic care." Our **Mission** is to change the health of our community one family at a time.

We are very serious about your health and that of your family. Subluxations (nerve interference) greatly decrease your body's health potential and rob you of your quality of life. We will ask you to be as dedicated as we are to allow chiropractic to be a major factor in your journey to health.

Insurance Coverage - We have been asked to join many of the HMO\PPO organizations in the area; we respectfully declined these offers after finding out they drastically limit the quality of your care. To be able to offer you more affordable care, it is our policy not to bill health insurance companies. All our practice members pay us directly; we will provide you with a "super bill" for you to submit to your insurance company. It is a good idea to contact your insurance company and find out what your policy coverage is before you begin care. If your insurance company requires more documentation than a "super bill", there is a separate service fee for each visit. Payment in full is always appreciated; however, affordable payment plans are always available for those who need them.

If you have not attended our "New Patient Orientation" please do so. This class provides you with information about all the services offered at our office. The purpose of the orientation is to answer questions about your health, to explain how your body heals and to share with you the knowledge that will allow you to receive the most from your chiropractic care. The orientation is also great opportunity for your friends and family to ask questions and better understand the benefits of corrective chiropractic care. Patients who truly understand how and why chiropractic works always get better results.

God has blessed us with Chiropractic. It is our privilege to share this with you. Please relax and enjoy as you learn how chiropractic can change your life.

I have read and understand the above office policy.

Patient Signature: _____ Date: _____

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This Document Constitutes Informed Consent for Chiropractic Examination and Care

When a patient seeks straight chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Straight 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.

The **Vertebral subluxation** is the misalignment of spinal bones causing interference to the mental impulses traveling over the nerve pathways. The objective of straight chiropractic is to analyze the spine and locate and correct these vertebral subluxations. The straight chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

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 non-chiropractic or unusual findings, we will so advise you. If you desire advise, 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize the doctor to perform a chiropractic examination to determine the presence of vertebral subluxation.

I hereby authorize the taking of x-ray films if necessary. I further agree that the above-mentioned doctor shall be the custodian of these x-rays.

All questions regarding the doctor's objective pertaining to detection of vertebral subluxation have been answered to my complete satisfaction.

I, _____ have read and fully understand the above statement.
(PRINT NAME)

(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 hereby grant permission for my child to receive a chiropractic examination and adjustment if necessary.

(SIGNATURE)

(DATE)