DESERT MOUNTAIN HEALTH CENTER

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and the chiropractor accepts a patient for such care, it is essential for both to be working toward the same objective:

Chiropractic has only one objective, and it is important that each patient understand both that goal and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Health is defined as the state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation is a misalignment of one or more of the vertebrae in the spinal column (or other body joints) or an elongation or twisting of the spinal cord and associated nervous tissue. Subluxations are caused by physical, emotional, mental or chemical stress from which the body and mind could not recover. Subluxations can cause alteration of nerve function and interference to the transmission of physical and mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment is the specific application of forces that aids the body in correcting subluxation.

Meridians are pathways of electromagnetic energy that exist in the body. They also must be free of interference in order for 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 subluxations or interference. However, if, during the course of a chiropractic 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 a health care provider who specializes in that area.

Regardless of what a 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 interference to the expression of the body's innate wisdom.

I _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives in regard to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

(patient's or guardian's signature) (date)

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PATIENT INFORMATION

First name: _____ MI:_____ Last Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Work Phone: ( ) _____

Email (optional): _____

Soc. Sec.# _____ Birth Date:_____ Age: _____

Sex:_____ Marital Status:_____ Occupation: _____

I was referred to this office by: _____

Responsible Party:_____ Relationship: _____

Address:_____

City: _____ State: _____ Zip: _____

Employer: _____

Emergency Contact Name: _____

Phone:( ) _____ Address: _____

Will your services be billed to health insurance or Medicare? _____

If so, complete the following:

Insured person: _____ Relationship: _____

Ins. Co. Name & address: _____

_____

Group no. _____ ID no. _____ Insured employer: _____

Do you have any other health insurance? _____ If yes, please specify: _____

_____

_____

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims. I request payment of benefits be made to this office.

Signature: _____ Date: _____