TERMS OF ACCEPTANCE **SpineCore Chiropractic**

EXPLANATION OF SERVICES

Routine activities regularly causes subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health. Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO

• We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.

• We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON'T DO / LIMITATION OF SERVICES

• We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.

•We do accept or bill insurance, Medicare, and/or any third-party carrier for payment.

• We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment.

• Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.

• In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

At the patient's discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan. All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them and for unmet deductible or coinsurance. All patients further understand and agree that we will submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare, or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage, unless otherwise required by applicable law.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location based upon these guidelines.

_____ _____
(Patient Signature) *(Date)*

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I,_____ of _____ have read and
(Parent or Legal Guardian) *(Child/(ren) Name)*

fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____
(Parent or Legal Guardian Signature) *(Date)*