



**Dr. Mike Mathes  
Dr. Melissa Mathes**

## TERMS OF ACCEPTANCE

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

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

**Adjustments:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. 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 disease and infirmity.

**Vertebral Subluxation:** 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 condition other than vertebral subluxation. 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 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 (vertebral subluxation) to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements  
Print Name

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO EVALUATE 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 be evaluated for subluxation.

## PREGNANCY RELEASE

By my signature I certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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