

Terms of Acceptance Form

I hereby request and consent to receiving chiropractic care, including wellness education, in this office by Dr. Seán Manning. The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

The chiropractic care that I will be receiving consists of adjustments whose purpose it is to improve neurological patterns and to enhancing my body's awareness of itself so that my body may develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation and healing.

I also understand that, in addition to chiropractic care and wellness education, my practitioner may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following: It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for nervous system integrity and wellness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and nerve system integrity, as a chiropractor the sole condition of concern is that of the subluxation.

The only condition we offer to diagnose and correct is the subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, the **TERMS OF ACCEPTANCE** and understand that the care in this office is different from what many consumers may expect from chiropractors. I agree to receive care, which consists of or includes chiropractic adjustments and wellness education. I understand that I am not passive in the process, that I am an active participant in my care and in my healing.

PRINTED NAME OF PRACTICE MEMBER

SIGNATURE OF PRACTICE MEMBER

DATE

PRINTED NAME OF WITNESS

SIGNATURE OF WITNESS

DATE