THE NEW YORK CHIROPRACTIC LIFE CENTER, PLLC
91 Central Park West, N.Y., N.Y., 10023
212-580-3350

TERMS OF ACCEPTANCE

At The New York Chiropractic Life Center, 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, and that is to eliminate vertebral subluxations. On a daily basis, we experience physical, chemical and emotional stresses that often accumulate and result in these vertebral subluxations, which in turn can cause a serious loss of health and well-being. 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessoning of the body's innate ability to express its maximum health potential. Often times, the effects of these vertebral subluxations are gradual in nature and can remain undetected until they become severe. Symptoms are usually the last things to show up in the disease process and the first to disappear as the correction begins

Adjustment: 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, by hand or mechanical means.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

We do not offer to diagnose or treat any disease. We only offer to diagnose vertebral subluxations and associated conditions. 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 another health care provider that 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.

CARE CHOICES: Patients come to our office for a variety of reasons.

Crisis/Relief Care: symptomatic pain relief (patch-up care). It corrects the most recent layer of spinal or neurological damage.
Reconstructive/Corrective Care: cause of problem corrected as well as symptomatic relief (fix-up care). Concerned with corrected years of damage that occurred when there were few symptoms
Wellness/Maintenance Care: for relief and spinal correction in addition to looking forward to maintaining heightened state of wellness and vitality.

Please choose type of care that best fits your health and life style goals.
❑ Relief care ❑ Corrective Care ❑ Wellness care ❑ I would like the doctor to select the appropriate care _____ *(initial)*

I understand that no guarantee of assurance will be made or has been made to the results that may be obtained. I further understand that if my care requires x-rays to be taken, the fee paid for this service is for analysis only. The actual films are the property of The New York Chiropractic Life Center. Once films are used for the purposes of care, they cannot be released. Copies may be made if necessary, at a nominal fee.

I clearly understand and agree that all fees for services rendered to me are ultimately my responsibility.

I, ___________________________________, have read and fully understand the above statements.
(please print your name). ***Initial and Date*________/______**

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

____ _______________________
(signature) (date)

Pregnancy Release:
This is to 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: _____________________ ***Initial and Date*________/______**

Consent to evaluate and adjust a minor / child

I, _____________________________________, being the parent or legal guardian of ___________________________________ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ________________________
(signature) (date)