

**SERENDIPITY CHIROPRACTIC  
TERMS OF ACCEPTANCE**

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustment to the spine.

**HEALTH:** The state of optimal physical, mental, and social well-being, not merely the absence of disease or 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 the diagnosis or treatment of any disease. **We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions.** However, if during the course of a chiropractic spinal examination we encounter unusual findings which are outside the scope of practice for a Doctor of Chiropractic, 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(printed name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**Consent to evaluate and adjust 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 receive chiropractic care.

**Female patients of child-bearing capability pregnancy release**

This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Barbara Lowell has 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 cycle: \_\_\_\_\_

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)