*Auburn Chiropractic Health Clinic, Inc.*
*Dr. Douglas Owens Pitt*

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*Auburn, AL 36830*

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# 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 the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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.

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

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 lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or 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 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 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.

I, _____, have read and fully understand the above statements.
(PRINT NAME)

I therefore accept chiropractic care on this basis.

_____ _____/_____/_____
(SIGNATURE) (DATE)

Consent to Evaluate and Adjust a Minor Child

I, _____, being the parent or legal guardian of
(PRINT NAME)
_____, have read and fully understood the above terms of
(PRINT CHILD'S NAME)
acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____/_____/_____
(SIGNATURE) (DATE)