DOVER FAMILY CHIROPRACTIC – TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. **We do not offer to diagnose or treat any disease**. We only offer to diagnose either vertebral subluxations or related neuro-musculoskeletal conditions. 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 an appropriate 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 TYPE OF INTERFERENCE TO THE ESPRESSION OF THE BODY'S INNATE WISDOM. Our primary method is specific adjustment to correct vertebral subluxation(s). We may use other procedures to help your body maintain the adjustments.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column causing alteration of nerve function and interference with the transmission of mental impulses. This results in a decrease in the body's ability to express its maximum health potential.

ATTORNEY REPRESENTATION: (If Applicable)

I specifically authorize and instruct my attorney, _____, to disperse any funds available to me from any source directly to Dover Family Chiropractic prior to the dispersal of any funds to me. Dr. Errico, Dr. Bohl, and Dr. Hughes agree to keep the patient informed in the event of any difficulty he encounters in obtaining attorneys cooperation so patient can make appropriate determination in that regard.

I further agree that any balance incurred to me after the statute of limitations has been reached or the PIP insurance allowable has been exhausted, I will at that time become a cash payment patient.

MISSED APPOINTMENT POLICY:

I agree to provide this office a minimum of 24 hours advanced notice if a scheduled appointment must be cancelled. Furthermore, I agree to pay the sum of $20.00 in the event that I am unable to provide such notice (two such occurrences are permitted per calendar year without charge). I also understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

COLLECTION CLAUSE:

By my signature or that of my Guarantor, I realize the obligation of payment for professional services rendered by them and agree to pay any related fees in collection of said charges to include, but not limited to attorney fees, court costs, collection service fees, a fee for partial payment made on a past due account, or any fee by whomever may otherwise act as an agent.

I further acknowledge that I have had the opportunity to ask Dr. Errico, Dr. Bohl, Dr. Hughes, or his staff at Dover Family Chiropractic any and all questions I may have about this document to be sure I understand its terms.

MY SIGNATURE ON THIS AGREEMENT SIGNIFIES THAT I HAVE READ THIS DOCUMENT IN FULL AND AGREE TO ITS TERMS.

_____

PATIENT/GUARDIAN DATE WITNESS DATE