Dr. Marilyn Peterson
2519 Parkwood Rd
Snellville, GA 30039
404-692-4669

BSC 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 towards the same objective.

Chiropractic has only one goal. It is important that each patient understand, both the objective and the method used to obtain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

HEALTH: A 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 movable vertebra in the Upper Cervical spinal column which causes alteration of the 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 diseases or conditions other than a vertebral subluxation. However, if during the course of a Chiropractic 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 healthcare 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 VERY SPECIFIC MAJOR INTERFERENCE IN THE CENTRAL NERVOUS SYSTEM (SUBLUXATION).

I, _____, have read and understand the above statements.

(Print Name)

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

I, therefore, accept Chiropractic care on this basis.

Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

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.

Signature of Parent/Guardian _____ Date _____