Agreements and Office Policies

A. TERMS OF ACCEPTANCE: In our relationship of care at this office it is important for you to understand the objective of our treatment program and the methods used to reach it. The greatest failure here would be confusion and disappointment in our objectives of working together.

OUR OBJECTIVE chiropractically is to address vertebral subluxations, neuromuscular conditions, and metabolic health issues. We understand subluxations to be of two general types, *vertebral* and *meningeal*. Vertebral subluxations are improper relationships of function between two adjoining segments of the spine that cause alterations of nerve function, resulting in a lessening of the ability to manifest normal maximum health.

Meningeal (latin for 'coverings') subluxations are stresses and dysfunctions of the tissues that cover the spinal cord and brainstem – inside of the spine, and cranium. These meningeal tissues determine the shape, tone, and function of the central nervous system and support the patterns of vertebral misalignments.

Regardless of what a disease may be named, our primary objective is to eliminate the interference to the body's innate potential to express its maximum health and recover from held stresses and dysfunction. We do this by chiropractic adjustments and procedures to help your body hold the adjustments.

Various laboratory tests and in-office examination procedures will be utilized, when appropriate, to help determine nutritional and metabolic imbalances. All therapeutic measures are based on the intention of recovering the body's innate wisdom potential to recover from stresses, chronic adaptations and compensations, and dysfunctions affecting the body, speech (energetic systems), and Mind.

If during the course of our care we should find non-chiropractic or unusual findings, you will be advised. If you desire diagnosis or medical treatment for such findings, you will be recommended to the services of another health care provider.

B. PAYMENTS AND INSURANCE: I understand and agree that Health Insurance policies are an arrangement between an insurance carrier and myself, and that all fees for services are due and payable at the time treatment is rendered. Furthermore, I understand that the Doctor's office will prepare any necessary standard reports and forms to assist me in making collections from my insurance provider. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service, unless otherwise arranged.

C. MISSED APPOINTMENTS: I understand and agree that missed appointments and cancellations of less than 24 hours notice will be charged a full office visit fee and that I am personally responsible for this payment.

D. CONFIDENTIALITY: I understand that Stillpoint Health Center and the office of Dr. Robert B. Norett maintains strict confidentiality with my personal and health information, compliant with HIPPA procedures as required by law. Please refer to "HIPPA Notice of Privacy Practices" at www.StillpointHealthCenter.com.

I have read and understand the above statements, the objectives of care at this office, and agree to and accept chiropractic care on this basis.

_____ _____

signature date

Consent to evaluate and adjust a minor or child:

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

_____ _____