Office Policies and Terms

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. 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.

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 manual and instrument adjustments of the spine.

HEALTH

A state of optimal physical, mental and social well-being, not merely the absence of disease 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 it's 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 in particular, we recommend that you seek the services of a health care provider who specializes in that area.

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 is to eliminate a major interference to the expression of the body's innate wisdom and healing. Our method is specific adjusting of the spine to correct vertebral subluxations.

I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon request. I now authorize Dr. J. Noah Haynes D.C. or any Haynes Chiropractic appointed associate to proceed with any necessary treatment.

I have read and understand the above statements.

Signature_____ Date_____

Witness _____ Date_____

Your signature above constitutes your permission for Haynes Chiropractic to contact you with information via mail, e-mail, fax and phone.

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. J. Noah Haynes D.C. and whomever he may designate as his assistants to administer, as he so deems necessary to my child or children_____.

Name_____ Signature_____ Date_____

Witness_____ Date_____