POJERO FAMILY
CHIROPRACTIC

153 Main Street, #2, Sayville, NY 11782 | (631) 244-0300
info@pojerofamilychiropractic.com | www.pojerofamilychiropractic.com

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, and when a chiropractor accepts that person for care, it is essential that both parties are seeking and working for the same goals.

We have one goal as chiropractors, it is important that you understand this goal and the means that will be used to attain it. In this way there will be no confusion, misunderstanding, or disappointment.

The purpose of chiropractic care is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine, which when they interfere with the function of the nerve pathways, are called VERTEBRAL SUBLUXATIONS. They come from many causes and prevent the body from working properly.

By means of a chiropractic adjustment, SUBLAXATIONS are corrected, restoring normal nerve function. Our goal as chiropractors is to correct or reduce these SUBLAXATIONS so that every part of the body may have proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supple, health improves. In some, symptoms clear up quickly. For others the process is slower, in some it only partial, or not at all.

Regardless of he disease or ailment, I do not offer to diagnose, treat, heal or cure it. My goal as a chiropractor is to allow the innate power in the body to do its job as best as it can without nerve interference. This goal is accomplished by the correction of VERTEBRAL SUBLAXATIONS.

The chiropractic evaluation and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic.

CONSENT TO CARE

I do hereby authorize the doctors of Pojero Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable, and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I have read, understand and hereby request Chiropractic care based on the above agreement.

_____ _____

Name *Date*

_____

Signature

_____ _____

Signature of Parent or Guardian (if minor) *Relationship*