MOUNTAIN COMMUNITY CHIROPRACTIC WELLNESS CENTER
Dr. Tirrell S. Magnuson
760 S. Haywood St, Waynesville, NC 28786
828-226-6089

TERMS OF ACCEPTANCE and FINANCIAL AGREEMENT

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 its maximum health potential.

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 adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will 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 the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ Payment in full will be expected for any charges on the day of service.

_____Scheduled office visits require a **24 HOUR NOTICE OF CANCELLATION**. I understand and agree that if I do not provide proper notice I become responsible for the usual and customary charge for office visits.

_____Our office ***DOES NOT TAKE ANY*** insurance. We do not file/generate insurance claims.

_____ Please **DO NOT WEAR PERFUME OR COLOGNE** when visiting our office due to patients with allergies/chemical sensitivities.

I have read and fully understand the above statements. 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.

_____ _____
(print name) (signature)

_____
(date)

To be completed by patient's representative (minor child or physically / legally incapacitated).

I give Dr. Tirrell Magnuson permission to treat: _____
Name/Date