HEALTH & WELLNESS SOLUTIONS
FAMILY CHIROPRACTIC, INC.
2986 W. Ina Rd. Suite 100
Tucson, AZ 85741

TERMS OF ACCEPTANCE & CONSENT FOR CARE

The purpose of this consent form is to help you better understand the nature of the services offered in this office, and our mutual responsibilities. This will prevent any misunderstandings regarding expectations.

I hereby request and consent to receiving spinal care, including wellness education in this office by Dr. Sánchez, who provides Network Chiropractic/Network Spinal Analysis (NSA) care (a low force approach that has unique outcomes and clinical results) which he is professionally and personally confident in with regard to its safety and effectiveness. NSA care involves the development of new and unique spontaneous spinal wave motions and other body movements & oscillations. These waves, which are suggested to be associated with greater spinal stability, the re-distribution of energy, and the transfer of internal information, are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I understand that NSA does not attempt to manually manipulate spinal fixations structurally (often associated with a snapping or popping sound) nor does it directly treat painful areas of the spine and/or body. ***Instead, by enhancing my body's awareness of itself and specifically my spine (my sense of self), I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.***

Network Adjustment: The specific application of gentle touch force at Spinal Gateways™ located along the spine to achieve greater communication between the brain and body, develop new sensory and motor strategies for self-regulation of tension patterns and enhanced levels of self-organization, and facilitate the body's correction of vertebral subluxations.

Vertebral Subluxation: A misalignment of one or more vertebrae in the spinal column secondary to alterations in nerve function, which are caused by stress (emotional, chemical, and/or physical) that is perceived by the body-mind to be beyond its ability to adapt to. This state leads to a decreased ability to express one's optimal health and human potential.

I understand that the care offered at this office **IS NOT** a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or condition; nor are opinions or advice regarding such, or treatment prescribed by others, offered at this office. Should I desire advice, diagnosis, or treatment of any symptom, disease, or condition, it is recommended that I seek the services of a health care provider who specializes in that area.

(Continued on Other Side)

I understand it is common for individuals receiving NSA care to experience a wider range of motion and emotion during care, and that it is common as care progresses, to find new options in the body and in life, which often lead to significant life changes. ***This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, and experience of the body-mind, emotion, and consciousness.***

Rather than attempting to simply return me to my previous state minus a symptom, Dr. Sánchez chooses to help me achieve new levels of wellness and life potential that I may have never had before.

I have read, or have had read to me, the TERMS OF ACCEPTANCE & CONSENT FOR CARE, and ***understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of, or includes, NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.***

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

I hereby accept chiropractic care in this office on these terms.

_____
(Printed Name)

x_____ _____
(Signature) *(Date)*

Consent to evaluate and adjust a minor (under 18 years of age)

I, _____, being the parent or legal guardian of

_____

have read and fully understand the above terms and hereby grant permission for my child(ren) listed above to receive chiropractic care.

x_____ _____
(Signature) *(Date)*