Island Health & Chiropractic

9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110
Lucia Vracin, DC ~ Jerry Nashman, DC

Terms of Acceptance

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

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. 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 computerized adjustments and or gentle manual adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at it's optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated. Any legal disputes with Island Health & Chiropractic (I.H.C.), or employees of I.H.C. will be handled via arbitration.

I, _____ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

_____ _____

(patient signature) (date)

****Consent to evaluate and adjust a minor child**

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

_____ _____

(authorized signature) (date)

****Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____

_____ _____

(patient signature) (date)

**if applicable