NETWORK SPINAL ANALYSIS™ (NSA) CARE
Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides Network Spinal Analysis (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This practitioner provides care in accordance with both the **Council on Chiropractic Practice Guidelines** and the mission and values of **The Association for Reorganizational Healing Practice.** My doctor(s) has/have been trained in traditional chiropractic care and in the procedures of Network Spinal Analysis Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, 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.***

NSA consists of gentle touch contacts along the neck and back to achieve greater *communication* between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and or abstracts in this office.

I am aware that I will be receiving gentle touch Network adjustments, also called spinal entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, re-assessments will be performed, which include my personal perception of my wellness, my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity, and my ability to self-regulate tension and to re-organize my spine.

NSA is advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements and oscillations. These waves, which are suggested to be associated with the 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 also understand that aside from utilizing NSA care and wellness education, my practitioner(s) may perform addition examinations or assessments, or offer health/spinal care or advice consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and 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 malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind, and develops new strategies for spinal and nerve system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses to find new options in the body, and in life, which often leads 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, experience of the body-mind, emotion, and consciousness.

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

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information is given to you and signed by you prior to commencing care.

In Network Care, we address these subluxations through the structural segmental distortion and spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal or neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, the CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS™ (NSA) CARE and understand that the care in this office is different from what many consumers may expect from a chiropractor 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.

PRINTED NAME OF PRACTICE MEMBER	SIGNATURE OF PRACTICE MEMBER	DATE
PRINTED NAME OF WITNESS	SIGNATURE OF WITNESS	DATE