

**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 nervous 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 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, 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.

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 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.

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PRINTED NAME OF PRACTICE MEMBER

\_\_\_\_\_  
SIGNATURE OF PRACTICE MEMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
DATE

**KINGSBURY WELLNESS CENTER**  
**Fred L. Kingsbury, DC**  
**18F Union Ave. – 1<sup>st</sup> Fl R.. Bound Brook, N.J 08805**