CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date: ____/____/________ Time: ________________________________ AM / PM

I have been informed by Dr. ________________________________ that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problems (or illness).

I authorize Dr. ________________________________ to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness)

Patient Signature: ____

Witness Signature: ____

To the best of my knowledge, I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Patient Signature: ____

CONSENT TO TREATMENT OF A MINOR CHILD (Patients birth to 18 years old)

I herby authorize Dr. and whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to ____________________ (name of child).

My relationship to child: ______________________

Dated at ________________________, ______
(City) (State)

The ________ day of ____________________, 20______
(Day) (Month) (Year)

Parent or Guardian Signature: ____

Witnessed Signature: ____

CHILD SUPERVISION POLICY (Children birth to 18 years old)

– Please do not leave children unattended; children must be with parents at all times while in the office.

– Please keep children quiet while in the office (we have patients resting and don't want to disrupt them).

– Resting tables and massage chairs are for patients only (unless told otherwise by Doctor or staff member).

– Employees only behind the front desk

I have acknowledged the above policies

Patient (or Guardian) Signature: ____ Date: ____/____/________