X-Ray Consent

The purpose for the x-rays about to be taken is to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. I understand that I must then make a determination to seek additional advice, diagnosis or treatment for the "unusual finding" from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ DOB _______/________/_______
Print Patient Name

____ Date _______/________/________
Patient or Authorized Person's Signature

I, Parent/Legal Guardian of child, hereby grant permission for my child to receive chiropractic examination and x-rays.

____ Date ________/________/________
Parent/Legal Guardian