



## X-RAY CONSENT

The doctor has explained that the purposes of the x-rays about to be taken are 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-ray, 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.

## CONSENT TO EVALUATE A MINOR CHILD

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

## PREGNANCY RELEASE

**FEMALES ONLY** - please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- The first day of my last menstrual cycle was on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date
- I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

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By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the purposes of x-ray examinations and how they contribute to my chiropractic care.

After careful consideration I therefore, do hereby consent to receive the diagnostic x-ray examination the doctor has deemed necessary in my case, and understand that all of the above releases/consents are valid for the duration of my treatment at Hill Family Chiropractic.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
DOB

\_\_\_\_\_  
Patient or Authorized person's Signature

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date