Spinal Wellness Chiropractic

2010 N. Plano Rd suite 101, Richardson, TX 75082

Consent to X-Ray

I hereby authorize Spinal Wellness Chiropractic Clinic and whomever the clinician designate as his/her assistant(s) to take x-ray of myself (or said minor)

Patient's Signature: _____ **Date**: _____

Signature of Parent or Guardian for a minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

Consent to X-Ray

Pregnancy Release

Must be completed for all females of childbearing age and signed in the patient's, parent's or guardian's own handwriting.

Date of onset patient's last menstrual period (LMP): _____

I hereby release Spinal Wellness Chiropractic Clinic from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

Patient's Signature: _____ **Date**: _____

Signature of Parent or Guardian for a minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____