CONSENT TO X-RAY

Patient Name _____I hereby authorize Dr. Scott and whomever he designates to take X-Rays of myself (or said minor).

Dated this _____day of _____, 20_____. Signature _____

Signature of Parent or Guardian _____ Witness_____

PREGNANCY WARNING

Patient Name _____ Date _____

❑ I understand that if I am pregnant and have X-Rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

❑ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-Ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	❑ Yes	❑ No	❑ Don't know
I could be pregnant:	❑ Yes	❑ No	❑ Don't know
I have had a tubal ligation:	❑ Yes	❑ No	❑ Don't know
I am late with my menstrual period:	❑ Yes	❑ No	❑ Don't know
I am taking oral contraceptives:	❑ Yes	❑ No	❑ Don't know
I have had a hysterectomy:	❑ Yes	❑ No	❑ Don't know
I have irregular menstrual periods:	❑ Yes	❑ No	❑ Don't know

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-Ray examination performed now.

AUTHORIZATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-Rays is for examination only and the X-Ray negatives will remain the property of this office. **The patient also agrees that he/she is responsible for all bills incurred at this office, as well as, collectors, court, and attorney fees. If my balance goes past 30 days, a 20% late fee will be applied to my balance monthly for 3 months and if no payment is made in the time, I will be sent to AWA Collection Agency at the end of 4 months.**

Patient Signature: _____ Date: _____

Guardian or Parent Signature: _____ Date: _____