

# PRECISION CHIROPRACTIC

## CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date: \_\_\_\_\_

I have been informed by Dr. \_\_\_\_\_ Gana \_\_\_\_\_ that diagnostic X-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. \_\_\_\_\_ Gana \_\_\_\_\_ to perform such radiographic examinations necessary to diagnose, and to administer whatever treatment deemed necessary to treat my present problem (or illness).

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

ATTN: Female Patients:

To the best of my knowledge I am NOT pregnant and/or the above named doctor has my permission to X-ray me for diagnostic interpretation.

Signed: \_\_\_\_\_