CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, treatments and performance of the diagnostic procedures. I understand that I am under the care and supervision of the attending physician (s) and it is the responsibility of the staff to carry out the instructions of such physicians (s).

X-RAY CONSENT FORM

I, _____, hereby release SANDERS CHIROPRACTIC of liability from complications that may arise from receiving any x-ray studies. I understand the inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnose and treat my condition.

ATTENTION FEMALE PATIENTS: I, _____, hereby certify to the best of my knowledge that I am not pregnant and release SANDERS CHIROPRACTIC of liability for any complications that may arise from receiving x-rays studies. I understand the inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnosis and treat my condition.

ATTENTION PARENTS: Please complete Parents Consent for minor children.

I, _____, being parent or legal guardian of _____
Hereby consent to the treatment and performance of diagnostic testing of this minor at SANDERS CHIROPRACTIC, by Dr. Kim Sanders or any legal agent of this office.

_____ _____
Printed Patient's Name Date

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Date

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