

AUTHORIZATION TO PERFORM X-RAYS, CONSENT FORM & FINANCIAL AGREEMENT

FINANCIAL AGREEMENT

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any and all balance due to Action Chiropractic Inc.

AUTHORIZATION FOR X-RAYS

I was advised that x-ray were a necessary component of a thorough spinal examination and a key component to aid in establishing the accurate diagnosis of my condition. Therefore, I authorize the doctor to perform the necessary x-rays to treat my condition. I have also been informed that all x-rays will be destroyed after 7 years.

FEMALE ONLY

To the best of my knowledge, I am not pregnant and the doctor has my permission to take x-rays for diagnostic purposes.

Initials _____

AUTHORIZATION OF TREATMENT

I hereby authorize the doctor to perform whatever procedures that are necessary to treat my condition.

Executed this _____ day of _____

Signed _____

FOR TREATMENT OF MINOR

I hereby authorize the doctor to perform the necessary examination and treatments, including x-rays as deemed necessary to treat my :

_____ (Relationship to minor)

_____ (Full name of minor)

Signed _____

(Parent or guardian of minor)