UNIVERSITY PARK CHIROPRACIC

Dr. Kevin D. Hancock, DC

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Patient Consent

I authorize Dr. Kevin D. Hancock, DC to perform a diagnostic x-ray examination on myself and to administer whatever treatment that is deemed necessary to correct my present problem or illness.

Patient Name_____

Signed_____ Date_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant and the Doctor has my permission to perform a diagnostic x-ray examination.

Signed_____ Date_____

If Patient is a Minor

I am the parent or legal representative of _____. I authorize the performance of diagnostic x-ray of this minor.

Signed_____ Date_____