Consent for Treatment & Authorization to Perform X-Rays

Date:_____ **Time:**_____ **AM/PM**

I have been informed by Dr. Douglas LaRoss, D.C. 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. Douglas LaRoss, D.C. to perform such radiographic examinations necessary to diagnose and to administer the correct treatment is deemed necessary to treat my present problem or illness.

Signed:_____
Witness:_____

For Women Only

To the best of my knowledge I am NOT pregnant and Dr. Douglas LaRoss D.C. has my permission to x-ray me for diagnostic interpretation.

Signed:_____

Dr. Douglas LaRoss, D.C.
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