**Guyot Chiropractic: Consent for Treatment / Authorization to take X-rays**

Date:_____

Patient Name:_____

Patient's DOB:_____(Minor requires legal guardian's signature)

Provider witness/Staff:_____

I have been advised as to whether I need X-rays/exam, or I have furnished this information from an outside source. I understand this information is necessary to provide an accurate diagnosis to provide a treatment plan for my condition.

_____Exam: I authorize Dr. Douglas Guyot, D.C. to perform a diagnostic exam, which is necessary to determine the treatment for my musculoskeletal problem.

_____X-ray: I authorize Dr. Douglas Guyot, D.C./X-ray technician to take X-rays to complete an analysis of my present musculoskeletal problem.

_____X-ray: Provided from outside source.

Patient/Legal Guardian Signature:_____Date:_____

**Females Only:** To the best of my knowledge, I am not pregnant and am giving my permission, based on consideration of my birth control methods, for X-rays To be taken to determine my present musculoskeletal problem. Pt. Int:_____