Kellington Chiropractic

PATIENT CONSENT TO X-RAY

I _____ authorize the performance of diagnostic x-ray examination of myself which Dr. Kellington or her associate may consider necessary or advisable in the course of my examination or adjustments.

Signed_____ Date____/____/____

CONSENT TO X-RAY MINOR CHILD

I _____ authorize the performance of diagnostic x-ray examination of my child which Dr. Kellington or her associates may consider necessary or advisable in the course of his/her examination or adjustments.

Signed_____ Date____/____/____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and Dr. Kellington has permission to perform diagnostic x-ray examination. I have been advised that x-ray can be harmful to an unborn child.

Signed_____ Date____/____/____

PATIENT CONSENT TO CHIROPRACTIC

I _____ authorize the performance of Chiropractic care on myself which Dr. Kellington or her associates may consider necessary or advisable.

Signed_____ Date____/____/____

CONSENT TO CHIROPRACTIC EXAM ON MINOR CHILD

I _____ authorize the performance of Chiropractic care on my child which Dr. Kellington or her associates may consider necessary or advisable.

Signed_____ Date____/____/____