

Scott Chiropractic Center, P. C. 2200 Fountain Drive, Snellville, GA 30078-2919
Phone 770-972-9160 Fax 770-978-1699

CONSENT TO X-RAY

Date: _____

Patient: _____

DOB: _____

Patient Account Number: _____

I, _____ do hereby authorize a diagnostic x-ray examination which Scott Chiropractic Center, P.C. may consider necessary or advisable in the course of examination or treatment. I understand that there is a fee for this service, which I am responsible for at the time of services and rendered unless prior arrangements have been made.

Patient Signature

Date

FEMALE ONLY

I, _____, in signing this form state to the best of my knowledge that there is NO PREGNANCY confirmed or suspected at this time.

Patient Signature: _____ Date: _____

Witness _____ Date: _____