SPRING GROVE
PHYSICAL MEDICINE
& REHABILITATION

X-RAY CONSENT

I, _____, authorized Spring Grove Physical Medicine & Rehabilitation, LTD. to take x-rays for my condition. These x-rays are valuable information in order to assist my doctor in his/her evaluation of an initial treatment plan.

Patient Signature: _____ Date:_____

Witness:_____Date:_____

FEMALES ONLY:

This is to certify to the best of my knowledge I am not pregnant and Spring Grove Physical Medicine & Rehabilitation, LTD. has my permission to take x-rays.

Patient name: _____

Patient Signature:
_____Date:_____

Witness:
_____Date:_____

I understand my x-rays and other pertinent information related to my treatment will be presented to a Board Certified Radiologist for analysis. I further understand 1.) the sole purpose of this analysis is to identify spinal subluxations, biomechanical abnormalities, and pathology analysis; 2.) this information is valuable in order to assist my doctor in his/her evaluation of an initial treatment plan, as well as modification to this plan during the course of treatment.

Patient Signature: _____ Date:_____

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS VALID AND EFFECTIVE AS THE ORIGINAL.