LOGAN UNIVERSITY
CHIROPRACTIC HEALTH CENTERS

_____
Please Print Patient's Name

LOGAN UNIVERSITY CHIROPRACTIC HEALTH CENTER
CONSENT TO IMAGING STUDIES

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

INFORMATION ABOUT X-RAY STUDIES **PATIENT INITIALS** _____

Your condition may require additional diagnostic studies including but not limited to diagnostic x-rays. These are ordered so that your doctor can provide you with the best possible care. Before you consent to any additional diagnostic study, your doctor will explain the benefits and risks associated with the procedure. Body exposure to ionizing radiation is associated with an increased risk for developing genetic mutations or cancer. The dosage utilized in producing diagnostic x-rays is very minimal, well below the dosage documented to have negative impact on a person's health. However, as these effects are cumulative over a lifetime, your doctors strive to minimize your exposure by using state of the art equipment and protocols. The benefits of having these images available to better understand your health status outweigh the minimal risks associated with the exposure and have been assessed by your doctor and your doctor-of-record.

FEMALE PATIENTS: **This is to certify that to the best of my knowledge I am NOT pregnant and that my doctor has my permission to take x-rays. The beginning date of my last menstrual period was: _____.**

❑ **INFORMATION ABOUT DIAGNOSTIC ULTRASOUND STUDIES** **PATIENT INITIALS** _____

At the present time there are no known side effects associated with diagnostic ultrasound imaging.

★ **DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read □ or have had read to me □ the above explanation of x-ray studies.

I have discussed it with _____ (doctor's name) and have had my questions answered to my satisfaction.

By signing below I state that I have weighed the risks involved in undergoing the recommended diagnostic x-rays and have decided that it is in my best interest to undergo the procedure recommended. Having been informed of the risks, I hereby give my consent to this procedure.

Date	Date
Print Patient's Name	Print Witness' Name
Patient's Signature	Witness' Signature

I authorize my intern and clinician to take x-rays of _____ (minor child) as duly authorized in this form.

Signature of Parent or Guardian (If the Patient is a Minor) — Relationship to Minor