

## Please Print Patient's Name

## LOGAN UNIVERSITY CHIROPRACTIC HEALTH CENTER CONSENT TO IMAGING STUDIES

<u>To the Patient</u>: 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
ordered so that your doctor can provide you with the diagnostic study, your doctor will explain the benefits a ionizing radiation is associated with an increased risk for d producing diagnostic x-rays is very minimal, well below th health. However, as these effects are cumulative over a lif state of the art equipment and protocols. The benefits	best possible care. Before you consent to any additional and risks associated with the procedure. Body exposure to eveloping genetic mutations or cancer. The dosage utilized in the dosage documented to have negative impact on a person's fetime, your doctors strive to minimize your exposure by using of having these images available to better understand your he exposure and have been assessed by your doctor and your
FEMALE PATIENTS: This is to certify that to the best of m permission to take x-rays. The beginning date of my last	ny knowledge I am NOT pregnant and that my doctor has my menstrual period was:
INFORMATION ABOUT DIAGNOSTIC ULTRASOUND STUDIES	PATIENT INITIALS
At the present time there are no known side effects associa	ated with diagnostic ultrasound imaging.
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND SIGN BELOW.	O THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND
I have read $\square$ or have had read to me $\square$ the above explanat	cion of x-ray studies.
I have discussed it with (doc satisfaction.	tor's name) and have had my questions answered to my
	olved in undergoing the recommended diagnostic x-rays and procedure recommended. Having been informed of the risks, I
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 authorized in this form.	(minor child) as duly
Signature of Parent or Guardian (If the Patient is a Minor)	Relationship to Minor