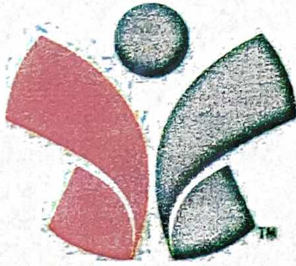

Crosby
Chiropractic
Center

X-RAY OPT-OUT/REFUSAL FORM

I, ____, understand that the following proposed radiograph(s): ____ will not be taken prior to my initiation of treatment. I realize proper diagnosis of any tumors, bone loss, fractures, lesions, fusions, or any other serious condition not otherwise mentioned, cannot be made without these x-rays being taken. I hereby release the attending doctor, Dr. Chad Thornton, and by extension Crosby Chiropractic Center, from any liability for undiagnosed conditions that could have been potentially identified with the recommended and/or customary x-ray imaging. I, therefore, take full responsibility for any preventable consequences as a result of my treatment here.

Patient Signature: ____ **Date:**__________
(Parent/Guardian)

Witness: ___________________________________ **Date:** ________________________