BIG IDEA FAMILY CHIROPRACTIC
3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

CONSENT FOR TREATMENT
AND AUTHORIZATION TO PERFORM X-RAYS

Name _____ Date_____

I authorize Dr. Gomez, DC and staff to perform a radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge, I am NOT pregnant, and the above-named Doctor and staff has my permission to x-ray me for diagnostic interpretation.

Signed: _____

Date of last menstrual cycle (If applicable): _____

The response you get from any treatment program is directly related to the commitment you give to the program. Results will depend on the regularity of your appointment schedule. We thank you for letting us help you with your chiropractic problem. No statement should be interpreted to mean that we can "cure" you.

NO GUARANTEE NOR ASSURANCE HAS BEEN MADE concerning results of the procedures. _____ Initial