MIDDLE TENNESSEE CLINIC OF CHIROPRACTIC
301 S Main Street, Suite D
Goodlettsville, TN 37072
(615) 860-3660

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date__________________________Time____________________AM/PM

I have been informed by Dr. Stephanie D. Fortney that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Stephanie D. Fortney to perform such 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 has my permission to x-ray me for diagnostic interpretation.

Signed: ____