



**CONSENT FOR TREATMENT AND AUTHORIZATION
TO PERFORM X-RAYS**

Date _____ **Time** _____ AM/PM

I have been informed by Dr. Shiels/ Dr. Wells 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. Shiels/ Dr. Wells to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

I understand that if I was honored the \$20 Certificate to Health, I must pay the FULL cost of X-Rays before they can be released to myself or any other health care provider.

(By Law, we are unable to release your X-Rays without full payment)

Signed _____

Witness _____

(WOMEN ONLY) 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 _____