
X-Ray Waiver

VOLUNTARILY ELECTION TO NOT HAVE DIAGNOSTIC X-RAYS AND LIABILITY WAIVER

In the course of an upper cervical consultation/examination performed by Dr. _____,
I was informed of the need for diagnostic x-rays.

I, _____, have **voluntarily elected** not to have this diagnostic procedure performed. This is being done against the recommendations of the above named chiropractor. I do not hold the above named chiropractor liable for any failure to detect or misdiagnose a subluxation due to the lack of the recommended x-rays.

My reason for not permitting these x-rays to be taken is:

I assume full responsibility for any conditions relating to my spinal/muscular health that may have been diagnosed had the recommended x-rays been taken.

_____ Signature of patient	_____ Date
_____ Signature of chiropractor	_____ Date
_____ Signature of witness	_____ Date