EVOLUTION
INTEGRATIVE MEDICINE
Life in Balance

Evolution Integrative Medicine X-Ray Consent Form

I, _____ **(Patient Name)**, hereby authorize Evolution Integrative Medicine to perform X-Rays. I understand that the X-Ray procedure involves the use of a machine that takes pictures of the inside of my body and the results are used to diagnose any illnesses or physical conditions.

_____ **(Initial)** I understand that the X-Ray is a safe procedure, but there is a small risk of radiation exposure.

_____ **(Initial) FEMALES ONLY:** This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

_____ **(Initial)** I am also aware that the results of the X-Ray are intended for use by the Doctors at Evolution Integrative Medicine for new and existing patients. We do not take x-rays for other doctor's offices.

_____ **(Initial)** I have been informed of the benefits and risks of an X-Ray procedure, and I understand that I am free to refuse this treatment. I also understand that any questions I may have about the procedure have been answered to my satisfaction.

By signing this consent form, I give my consent for Evolution Integrative Medicine to perform the X-Ray procedure.

Patient Signature: _____ **Date:** _____