

Crowder Specific Chiropractic

PATIENT INFORMATION

Patient Name _____
LAST NAME
 Address _____
FIRST NAME MIDDLE INITIAL
 City _____ State _____ Zip _____
 Home Phone _____
 Cell Phone _____
 Email _____
 Sex ☐ M ☐ F Age _____ Birthday _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Date _____
 Employer / School _____
 Occupation _____
 Spouse's Name _____
 Spouse's Employer _____
 Spouse's Occupation _____
IN CASE OF EMERGENCY, CONTACT
 Name _____
 Relationship _____
 Contact Number _____
 Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

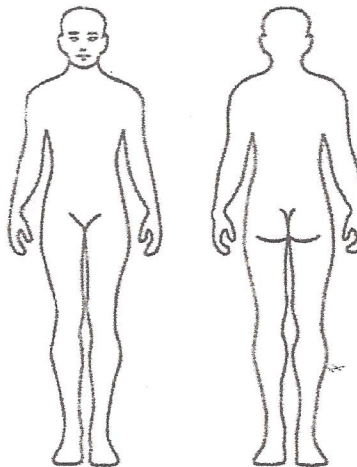
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Nagging | <input type="checkbox"/> Other _____ |



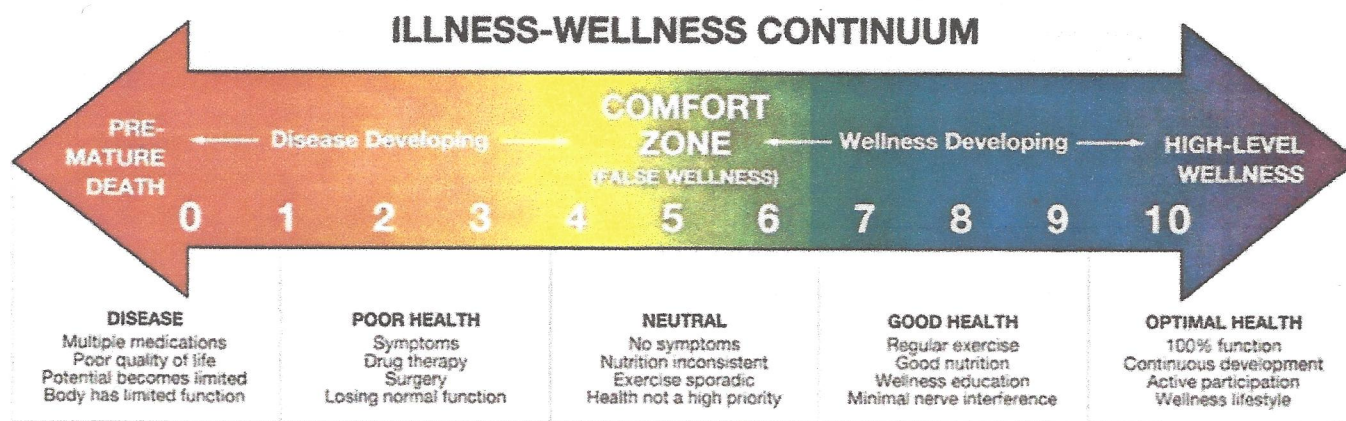
IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10
VERY

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues
(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Reproductive Issues | |

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

Crowder Specific Chiropractic
1502 W. University Dr. #107
McKinney, TX 75069
Phone (972) 562-0674 / Fax (972) 542-0710

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact: **Dr. Terry Crowder**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your written request, we will provide you with any revised Notice of Privacy Practices or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI protected. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for extended chiropractic care that your relevant PHI be disclosed to the health plan to obtain approval for that care. Dates and costs of services information may be disclosed to a third party when attempting to collect past due payments from you.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, chiropractic students, and chiropractic assistants for training fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to chiropractic school students and chiropractic assistants that see or assist our patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate if we need to change any information we currently have on file. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may leave a

message regarding specifics of the time and date of appointment with any person or device who answers at the phone number of record for you.

We will share your PHI with third party "business associates" that may at any time perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request in writing that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Facility Directories: Unless you object, to people that ask for you by name, (either in person or by telephone or electronic means), we will use and disclose verbally that you are on the premises or not on the premises (or disclose when you are expected or when you were last seen). Anyone who asks about you by name regarding your general condition or "how you are doing" will be told you are either "doing a little better" or "about the same" or "not doing too well". No specifics will be revealed except to those friends and family members you have indicated are directly involved with your healthcare, on the "Others Involved in My Healthcare Form" (see below).

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. You may affix additional names of family and friends (who may live at a distance or with whom the physician is not personally familiar), to this list by requesting a copy of our Others Involved in My Healthcare form.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government

agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may, upon written request, within ten business days, inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. You will be charged a reasonable fee for copying any records. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

While seldom a part of offices records forwarded by others to this physician, we must advise you that under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on

the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have specific questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by requesting a form entitled Others Involved in My Healthcare.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location (such as when traveling). We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment (for such things as long distance phone charges, etc.) will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request as needed, in writing, to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. This amendment can only be done to records that the physician has personally created, not those received from other providers of care. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Both your request and our rebuttal will then become a part of your personal record. If you would like to request an amendment to a portion of the record that was not created by this physician, that request and your explanation of the discrepancies will be added to your chart and become a part of the record, but the cited information itself will not be changed or purged. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for the facility, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer for further information about the complaint process.

This notice was published 4/28/2009 and becomes effective on 4/28/2009.

Receipt of Privacy Notice

Crowder Specific Chiropractic
1502 W. University Dr. #107
McKinney, TX. 75069
Phone: (972) 562-0674 Fax: (972) 542-0710

Patient Name _____
Date of Birth _____
Patient Number _____
Telephone _____

My signature, below, certifies I have received a copy of NOTICE OF PRIVACY PRACTICES.

Signature of Patient/Guardian

Date

Comments, if any:

Signature of Witness

Date: _____



CROWDER SPECIFIC CHIROPRACTIC

DR. TERRY S. CROWDER, D.C.

1502 W. UNIVERSITY #107

MCKINNEY, TX. 75069

PHONE: 972-562-0674

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Terry S. Crowder, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me. You are authorized to release information via email, mail, fax, or text only to myself concerning my treatment with Crowder Specific Chiropractic.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Dr. Terry S. Crowder, and send to 1502 W. University Dr. #107 McKinney, TX 75424.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Dr. Terry S. Crowder, and to send any and all checks to 1502 W. University Dr. #107 McKinney, TX 75424

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

Date: _____

1502 W. UNIVERSITY DRIVE, SUITE 107 ♦ MCKINNEY, TX 75069 ♦ 972.562.0674, METRO

Crowder Specific Chiropractic

X-Ray Consent Form

Patient Consent To X-Ray

I hereby authorize the performance of diagnostic X-Rays. Dr Crowder has requested the X-Rays for further diagnostic purposes. At this time I know of no other condition which the taking of X-Rays would further complicate.

Signed: _____ Date: _____

Consent To X-Ray A Minor

I am a parent or legal guardian of *(please print)* _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic X-Rays of said minor. Dr. Terry Crowder has requested the X-Rays for further diagnostic purposes. At this time I know of no other condition which the taking of X-Rays would further complicate.

Signed: _____ Date: _____

Females (12 years and older): Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. Dr Terry Crowder and the staff at Crowder Specific Chiropractic have 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.

Signed: _____ Date: _____

Females (12 years and older): Consent To X-Ray During Pregnancy

This is to certify that I am or may be pregnant and that Dr Crowder and the staff at Crowder Specific Chiropractic have my permission to perform diagnostic X-Rays involving any cervical spine (neck) or extremities (arms and legs), on the condition that lead shielding be utilized over the trunk of my body. I have been advised that certain X-Rays particularly those involving the pelvis-can be hazardous to an unborn child.

Signed: _____ Date: _____