Integrated
Complementary &
Alternative
Medicine Institute of Amarillo, LLC

1901 Medi Park, Suite 1001
Amarillo, TX 79106

806-468-4616

Fax: 806-468-4618

REGISTRATION

Name _____ Date of Birth _____ M F
Last First Middle

(If minor, also give parent's name.)

Address _____ City _____ State _____ ZIP _____

Phone _____ e-mail _____ Marital Status: _____

Occupation _____ Employer _____

Spouse's Name _____ Date of Birth _____
Last First Middle

Occupation _____ Employer _____

CONSENT TO TREAT:

The undersigned consents to receive integrated, complementary & alternative health care services provided by health care practitioners. Specific services may include diagnostic procedures, examinations, treatments, or other services rendered under the special instructions of the practitioners.

The undersigned understands that treatment modalities offered at ICAM may differ from conventional allopathic medicine.

Signature: _____ Date: _____

Witness: _____ Date: _____