

Integrated
Complementary &
Alternative
Medicine
Institute of Amarillo



1901 Medi-Park Drive 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: _____

Home Phone: _____ Cell/Daytime Phone: _____

E- mail: _____ Marital Status: _____

Occupation: _____ Employer: _____

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

Occupation: _____ Employer: _____

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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: _____

Note: Payment is expected at time of services rendered and is the responsibility of the client. Clients may submit charges to their insurance carrier, with the understanding that services may or may not be covered. Services are not refundable.

