ACUPUNCTURE INTAKE
CONFIDENTIAL INORMATION

Welcome!!!!!! We want to make your appointment as pleasant and comfortable as possible. If at any time you have any questions regarding your visit, please let us know.

Please Print E-mail:_____

Name _____ Home # _____ Work # _____

Address _____ Town _____ ST _____ ZIP _____

Date of Birth _____ Age ____ Male ___ Female ___ Marital Status _____

Occupation _____ Referred by _____

Cancellation Policy

If a scheduled appointment with the acupuncturist cannot be kept, kindly give us 24 hours notice. There is a full service fee charge for appointments cancelled after that time.

Consent to Treat

I voluntarily authorize Integrative Therapeutics to perform an acupuncture evaluation and procedures. I understand it is my responsibility to ask about any procedure that I do not understand.

Acknowledgement of Terms

By signing below I attest that all information given is true and accurate to the best of my ability. I understand that intentionally providing misleading information is unlawful. I have read and understand all of the policies stated above. I acknowledge that I am ultimately responsible for charges incurred as a patient of Integrative Therapeutics.

I understand and agree to all the above stated policies _____
Print Name

_____
Signature

Today's Date _____