Life's essence
Clinic of traditional
Chinese medicine

My signature below shall indicate that I have received life's essence Clinic *Notice of Privacy Policies* and I understand that my medical and billing information (or that of my minor child/dependant) can and will be used and/or disclosed for the purpose of treatment, payment collection and other medical services.

Name:_____ D.O.B._____

Signature: _____Date: _____
(Patient, Parent or Guardian) (Relationship to Patient)