EASTERN SCHOOL OF ACUPUNCTURE AND TRADITIONAL MEDICINE

I HAVE READ AND UNDERSTOOD THE NOTICE OF PRIVACY POLICIES OF THE INTERN CLINIC AT THE EASTERN SCHOOL OF ACUPUNCTURE AND TRADITIONAL MEDICINE.

I ACCEPT THE TERMS OF THIS AGREEMENT.

_____DATE_____
Patient of Representative (relationship to patient)

_____DATE_____
Eastern School of Acupuncture Staff Member

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