

Electromagnetic Millimetre Wave Therapy for pain relief

BOOKING FORM

Please make appointment for **EMT Therapy** at Ph: 03 9804 0646
Report to NIIM Reception, level 2 with this form at the appointment.
Ring Nik on 6044 when patient at reception.

Date/ Time

1. PATIENT DETAILS				
Title	Surname	First name	DOB	M / F
Street address		Suburb	State	Postcode
Phone ()	Mobile		Email	
2. REQUESTING PRACTITIONER				
Full name				
PRACTITIONER SIGNATURE			DATE (dd/mm/yy)	
3. Electromagnetic Millimetre Wave Therapy (EMT) for pain relief				
<input type="checkbox"/> 1 st session		free		
<input type="checkbox"/> 15 min session(s)		AUD \$ 30 each		
4. CONSENT (A): By signing below, I the person undertaking the therapy:				
(i) Give my consent to NIIM to use the EMT device as instructed and at my own risk;				
(ii) Give my consent to NIIM to collect my data for medical research development and statistical analysis.				
PATIENT SIGNATURE: _____			DATE: _____	
5. PAYMENT SECTION				
<input type="checkbox"/> Cash or Cheque				
<input type="checkbox"/> VISA <input type="checkbox"/> Mastercard		Card Number	Expiry date (mm/yyyy)	
Cardholder's name	Cardholder's signature		Amount AUD \$ _____	

OFFICE USE ONLY

PAID _____