MRN # ________________

Ithaca Free Clinic
Request for Treatment/Informed Consent for Treatment

Name ____________________________________ **Date** ___________________

What is your reason for coming to the Ithaca Free Clinic (IFC) today?

The IFC combines the best of alternative and complementary treatments with mainstream medicine to provide care for the whole person: mind and body.

Insurance coverage is not needed, services are provided free of charge.

You need to write which practitioner from our multidisciplinary team that you want to see. While you may see more than one of these practitioners over time, select one for this visit:

Practitioner you are Seeing Today:
____
(Name and/or Practice)

Our physicians/practitioners might want you to get blood tests for diagnosis and treatment. Results will be returned to the IFC and might require that you come back for further treatment and/or be contacted with the results. Please be sure we have a way to get in touch with you.

Note that only physicians, chiropractors, and nurse practitioners have a licensed to diagnose disease or prescribe medication. Therefore, if you are not reasonably certain about what your current problem is, we advise you to be evaluated first by a physician or nurse practitioner.

Acupuncturists and massage therapists are licensed to treat using their specific methods. Some therapists, psychologists, social workers, or counselors are licensed to diagnose and/or treat emotional or relationship issues.

Herbalists, Energy Workers and Reiki are not New York State licensed. Herbalist though will suggest herbs to take will and advise you in the use of herbs to treat the problem(s) you discussed in the session.

Your medical information will not be released/used unless you specifically request it to be. The only exception is that it will be available for use/review within the IFC and by the practitioners you see.

I hereby acknowledge that I am coming to the IFC by my own choosing. I authorize and consent to the medical/complementary service as indicated. I also consent to medical/contemporary services in addition to or different from the one indicated which the chosen practitioner deems necessary or advisable. I further agree to hold harmless the IFC, the Ithaca Health Alliance, and those practitioners I do not see from any legal or liability claim. The question of confidentiality, among and between the clinic Provider(s) and patients, is waived. I hereby authorize the practitioner I have selected at the IFC to administer treatment.

I, the undersigned, have read and understand the above information.

Signature of patient, parent or legal guardian:
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Request for Treatment/Informed Consent for Treatments RETURN VISITS

Name: ____ MRN #: _______________

---Having been a patient at the Ithaca Free Clinic on a previous occasion, and having read and understood the information contained on the reverse of this form at that time, I again agree to all the provision of such consent for treatment.

Date: __________________________ Reason for Visit Today: _____________________________

Practitioner I wish to see: ____

Signature of Patient, Parent or Legal Guardian:
____

---Having been a patient at the Ithaca Free Clinic on a previous occasion, and having read and understood the information contained on the reverse of this form at that time, I again agree to all the provision of such consent for treatment.

Date: __________________________ Reason for Visit Today: _____________________________

Practitioner I wish to see: ____

Signature of Patient, Parent or Legal Guardian:
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Signature of Patient, Parent or Legal Guardian:
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Date: ________________________ **Reason for Visit Today:** ___________________________

Practitioner I wish to see: ____

Signature of Patient, Parent or Legal Guardian: ____