Sample School Clinic Informed Consent

I, _____ (patient's name), HEREBY voluntarily request to receive clinical services from _____ (school clinic name). I consent that these services may include acupuncture, moxabustion, nutritional / dietary counseling, herbology, Bach flower essences, TuiNa therapeutic massage, and lifestyle counseling, among other related services. I acknowledge that no guarantees have been made to me as to the effect of such care.

I further acknowledge that none of the above services is meant to be construed by me as the diagnosis or treatment of disease, but rather as an aid to balancing my energy and to improving my general wellness.

I understand that the acupuncture clinic holds traditional Oriental medicine to be complementary to orthodox medical treatment, unless contrary medical advice is given. I am advised that if I am sick, I should consult my doctor.

I understand that prior to the beginning of any procedure, I will receive an explanation of its nature and purpose and any probable risks involved. I understand that I may refuse any and all services at any time.

I understand that the clinic is part of the acupuncture school and that, as such, its main purpose is the training of acupuncture interns. Interns are supervised by a faculty member who is a Board Certified Acupuncturist. Interns do not receive compensation.

I recognize that I am responsible for my health and wellbeing, and that it is my duty to myself to be an informed partner in the care I receive at the clinic. To this end, I will secure the self-knowledge that I need in order fully to work with my intern.

In the event that I am not able to keep my appointment, I will try to give at least 48 hours notice so that someone else can use the time. I will pay the fee of $25 for any cancellation that is made within 24 hours from the appointment time. If I do not show up for the appointment as scheduled, then I will pay the fee of $30.

I understand that payment by cash, check, or credit card is due at the time of service. Should I have a complaint or grievance regarding services, I will speak with the clinic coordinator.

Finally, I understand that all records will be kept confidential.

Witness	Date
Patient's Signature	Date

We are a fragrance-free facility.