HomeoWorks PLLC
Frank Russo, CCH, FNP-BC

CONSENT TO TREATMENT

I authorize HomeoWorks PLLC to treat my medical condition(s) and recommend diagnostic tests to be ordered through my primary care physician as needed. I recognize that treatments I receive may include homeopathic, nutrient, and/or supplemental therapies. This consent is intended to provide an opportunity for me to make an informed decision so that I may give or withhold my consent to treatment that may be considered alternative by physicians trained in the United States.

I understand that:

- The safety and efficacy of alternative therapies has not always been established with controlled studies to the satisfaction of conventional (allopathic) medicine.
- Side effects to homeopathic treatment (although uncommon) may include temporary worsening of present symptoms (aggravations) or temporary development of new symptoms (proving symptoms).
- No claim to cure has been made to me.
- HomeoWorks PLLC will NOT provide hospital or emergency care to me.
- The therapies I receive will complement the care I receive from my primary care physician.
- Homeopathic associates, consultants, and supervisors may be involved in my care.
- My case may be recorded or videotaped on request.

I have sought care from HomeoWorks PLLC. It has explained in detail the service I choose to receive. Interactions, reactions, and side effects regarding the treatment I receive has been explained in detail.

My signature below indicates that I have read the information in this document and agree to abide by its terms during our professional relationship.

Patient's Name (printed) _____

Signature_____ Date_____

Relationship to Patient (please circle): Self, Parent, Legal Guardian, Personal Representative

Other_____