Natural Pediatric Medicine, LLC – Dr. Robin Russell
536 Main Street, New Hartford, CT 06057 PO Box 46, Pine Meadow, CT 06061
(860) 909-1082 – Phone • (860) 238-4519 – Fax

Informed Consent

I, _____, hereby authorize Dr. Robin Russell to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

1. Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, glycerites, capsules, tablets, crèmes, plasters, or suppositories.
2. Common diagnostic procedures: venipuncture, Pap smears, radiography, laboratory, x-ray.
3. Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
4. Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
5. Medical use of nutrition: therapeutic nutrition, nutritional supplementation.
6. Minor office procedures: ear wax removal.
7. Psychological Counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Robin Russell regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I hereby give my consent to receive text and/or voice reminders for appointments and other information pertaining to the clinic operation (ex. Clinic updates, COVID pandemic information, etc.).

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Dr. Robin Russell to the best of her ability.

_____ _____

Date **Signature of Patient**