LUXE CONCIERGE NURSING, LLC
CONSENT FOR TREATMENT

Patient Name (Printed): _____ Date: _____

HEALTH CARE CONSENT: I request and agree to receive all services provided by the professionals authorized to care for me at with Luxe Concierge Nursing, LLC. I understand these services may include:

- Services provided under the direction or instruction of attending physicians and other authorized health care professionals.
- LCN provides nursing services only. LCN does not provide diagnoses but will consult with your healthcare provider as necessary in determining a plan.
- Routine procedures used for treatment.
- Additional or related treatments and procedures LCN determines are necessary and in my best interest including the use of photos, and video/audio monitoring and/or recording.
- Digital and telehealth services, including virtual (video) visits, online evaluation, telephone visits, consultation and between providers to assist in care.

I ALSO UNDERSTAND:

- There may be risks and alternatives to a particular treatment or procedure LCN recommends.
- My provider may need to explain and discuss certain treatments or procedures. It is important for me to ask questions or ask for more information about the care or treatment I may receive with LCN.

I UNDERSTAND THAT I HAVE NOT RECEIVED ANY PROMISES OR GUARANTEES ABOUT THE RESULTS I MAY EXPECT FROM MY CARE WITH LCN.

_____ _____
Signature of Patient (Age 14+) **Date**

_____ _____
Signature of Parent / Guardian **Date**