HeavenSent concierge nursing

CONSENT FOR TREATMENT

PATIENT NAME: _____ **DATE:** _____
Please Print

HEALTH CARE CONSENT

I request and agree to receive all services provided by the professionals authorized to care for me at with HeavenSent 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.
- HCN provides nursing services only. HCN 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 HCN 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 HCN 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 HCN.

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

PATIENT SIGNATURE: _____ **DATE:** _____
Patient Must Be 14+ Years Of Age

PARENTAL SIGNATURE: _____ **DATE:** _____
Parent or Guardian Consent Required For Those Under 14 Years Of Age