LUXE CONCIERGE CARE
CONSENT FOR TREATMENT

Client 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 Care. I understand these services may include:

- Services provided under the direction or instruction of attending physicians and other authorized health care professionals.
- LCC provides after care only. LCC 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 LCC 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 that your provider reccomends.
- Your 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 LCC.

I UNDERSTAND LCC IS NOT RESPONSIBLE FOR ANY COMPLICATIONS, INJURIES, OR PAIN ASSOCIATED WITH PROCEDURES OR CARE RENDERED BEFORE, DURING, OR AFTER SERVICES.

WE ARE A NON-MEDICAL BUSSINESS PROVIDING LUXARY SERVICES TO OUR CLIENTS.

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

_____ _____

Signature of Client **Date**