LanteRN Health Consulting, LLC
CONSENT FOR CARE

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 LanteRN Health Consulting, LLC ("LHC"). I understand these services may include:

- Services provided under the direction or instruction of attending physicians and other authorized health care professionals.
- LHC provides nursing services only. LHC 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 LHC 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:

- That my nurse(s) are licensed in their respected professions and will evaluate and advise me from the perspective of their training and within the scope of their practice.
- LHC does not provide physician services and none of our advice or approaches should replace needed medical treatment recommended by my primary care or specialty physician.
- LHC does not independently diagnose, treat, prescribe or cure any disease, mental or physical, outside the scope authorized by Idaho Law or IDAPA 24.34.01 and our care is not intended as a substitute for regular medical care by a licensed physician.
- There may be risks and alternatives to a particular treatment or procedure LHC recommends.
- My provider may need to explain and discuss certain treatments or procedures.
- My nurse(s) may not obtain, possess, furnish or administer prescription drugs to any persons except as directed by a person authorized by law to prescribe medication.

It is important for me to ask questions or ask for more information about the care or treatment I may receive with LHC.

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

_____ _____

Signature of Patient (Age 14+) Date

_____ _____

Signature of Parent / Guardian Date