Consent for Evaluation and Treatment

1. Purpose and Scope of Consent

I, the undersigned patient or authorized representative, hereby voluntarily consent to receive medical care, treatment, and services at **THE LUXE MEDICAL CLINIC** (hereinafter referred to as "the Clinic").

This consent includes, but is not limited to, the following services provided by the Clinic's physicians, physician assistants, nurse practitioners, nurses, and other licensed staff:

- **Routine Medical Care:** Examinations, assessments, diagnostic procedures (e.g., blood draws, urinalysis, basic imaging), and management of acute and chronic illnesses.
- **Preventive Care:** Vaccinations, immunizations, health screenings, and routine physical exams.
- **Minor Procedures:** Necessary procedures that can be performed in a primary care setting (e.g., simple laceration repair, wart removal, minor lesion biopsy).
- **Referrals:** The initiation of referrals to specialists, hospitals, or other health care providers as deemed necessary by my primary care provider.

2. Understanding of Treatment and Risks

I understand that:

- **Diagnosis and Treatment:** Healthcare is not an exact science, and no guarantees have been made regarding the results of any examination, diagnosis, or treatment.
- **Risks:** Every treatment and procedure carries some degree of risk, including but not limited to the risk of injury, infection, discomfort, or adverse reaction. I have been given the opportunity to discuss the potential risks, benefits, and alternatives to proposed treatments with my provider.
- **Refusal:** I have the right to refuse any recommended treatment or procedure at any time, and I understand that such refusal may impact my health and the effectiveness of my overall care plan.

3. Financial Responsibility

I understand that I am responsible for the payment of all services rendered, regardless of insurance coverage. I agree to pay any co-payments, deductibles, or non-covered charges at the time of service, unless prior financial arrangements have been made.

4. Assignment of Benefits & Release of Information (HIPAA/Privacy)

- **Assignment of Benefits:** I authorize payment of medical benefits directly to the Clinic for services rendered.
- **Release of Information:** I consent to the release of my medical information (including protected health information) to my insurance company, government payors (e.g., Medicare/Medicaid), and other authorized healthcare providers for the purposes of treatment, payment, and healthcare operations.
- **Notice of Privacy Practices (NPP):** I acknowledge that I have received or been offered a copy of the Clinic's Notice of Privacy Practices, which describes how my medical information may be used and disclosed.

5. Acknowledgment and Signature

By signing below, I affirm that:

1. I have read or had this form read to me.
2. I understand the scope of consent and the terms outlined above.
3. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction.
4. I grant my consent to treatment.

SIGNATURE: _____

PATIENT/GUARDIAN'S NAME: _____

DATE: _____