



## Clinical Nurse Consultant Consent Form

(Consent for Clinical Services Provided by Clinical Nurse Consultants)

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### 1. Consent to Services by Clinical Nurse Consultant

I voluntarily consent to receive healthcare services from a Clinical Nurse Consultant (CNC), including but not limited to:

- Health assessments and physical examinations
- Diagnostic screenings and review of clinical data
- Development or revision of care plans
- Patient and family education
- Monitoring and oversight of treatment implementation

I understand that the Clinical Nurse Consultant is an advanced practice nurse acting as a direct provider of care within their scope of practice.

### 2. Coordination of Care and Information Sharing

I authorize the Clinical Nurse Consultant to:

- Coordinate my care with other providers, including my Primary Care Provider (PCP) and facility staff
- Access and document in my medical records
- Share relevant medical information with authorized members of my healthcare team for continuity of care

All information will be shared in accordance with HIPAA and applicable laws protecting patient confidentiality.



### 3. Communication Consent

I authorize the Clinical Nurse Consultant or their clinical team to contact me (or my legal representative) using the following methods for follow-ups or health-related updates:

Phone  Voicemail  Text Message  Email

Preferred method of contact: \_\_\_\_\_

### 4. Financial Responsibility

I understand that I am responsible for any charges related to services provided by the Clinical Nurse Consultant that are not covered by insurance. This may include co-pays, deductibles, or services not reimbursed.

### 5. Consent Duration

This consent remains valid for the duration of services provided by the Clinical Nurse Consultant or until revoked in writing by me or my legal representative.

### 6. Acknowledgment and Signature

I acknowledge that I have read, understand, and agree to the contents of this consent form. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Responsible party/Guardian (if applicable): \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_