PACIFIC RECOVERY RETREAT

CONSENT FOR TREATMENT

Client Name: _____

Date of Birth: _____ Date: _____

1. CONSENT TO NURSING SERVICES

I voluntarily request and consent to receive concierge nursing and post-operative recovery services from Pacific Recovery Retreat. I understand that services are personalized to my individual needs and may be provided in my home, hotel, or other agreed-upon recovery setting.

Depending on my care plan and the services arranged, nursing services may include:

Personalized Post-Operative Monitoring: Assessment of my recovery status, monitoring of vital signs as appropriate, and observation for changes that may require medical attention.

Incision, Wound, and Drain Care: Nursing assessments, dressing changes, drain management, and related care within the nurse's scope of practice and applicable provider instructions.

Medication Support: Assistance with medication-related nursing care in accordance with applicable orders, instructions, and legal requirements.

Recovery Education: Guidance on post-operative precautions, wound care, infection prevention, hydration, mobility, and recognizing potential warning signs.

Comfort and Recovery Support: Individualized nursing attention intended to promote comfort, safety, and a supported recovery experience.

Care Coordination: Communication with my surgeon, physician, or other healthcare professionals, as appropriate and legally permitted.

I understand that the specific services provided will depend on my individual needs, the agreed-upon service arrangement, applicable medical instructions, and the nurse's scope of practice.

2. UNDERSTANDING THE SCOPE OF SERVICES

I understand that Pacific Recovery Retreat provides concierge nursing services and does not replace my surgeon, physician, or other treating healthcare professionals. Pacific Recovery Retreat does not independently diagnose medical conditions or prescribe treatment beyond the legal authority of its personnel.

I acknowledge that I remain under the care of my treating provider and am responsible for following my post-operative instructions and attending recommended follow-up appointments. If I experience an emergency or significant change in my condition, emergency medical services may be necessary.

3. RISKS, BENEFITS, AND ALTERNATIVES

I understand that nursing care may involve potential risks, benefits, and alternatives depending on the services provided. My nurse will explain relevant aspects of care when appropriate, and I may ask questions or request clarification before proceeding.

I understand that no specific outcome or recovery timeline can be guaranteed. Although Pacific Recovery Retreat strives to provide attentive, individualized nursing care, recovery varies from person to person.

4. CLIENT RIGHTS AND RESPONSIBILITIES

I understand that I have the right to:

- Receive respectful, professional, and confidential nursing care.
- Ask questions and receive explanations about the services being provided.
- Participate in decisions regarding my care.
- Decline a service or withdraw consent, subject to applicable legal requirements and discussion of any potential implications for my care.

I agree to provide accurate information regarding my medical history, medications, allergies, surgical procedures, and relevant post-operative instructions. I also agree to communicate new symptoms, changes in my condition, and concerns that may affect my safety or recovery.

5. PRIVACY, PHOTOGRAPHY, AND RECORDINGS

Pacific Recovery Retreat is committed to protecting the privacy and confidentiality of my personal and health information in accordance with applicable law.

I understand that this consent form does not authorize the use of my photographs, videos, audio recordings, or identifiable information for marketing, promotional, or social media purposes. Separate written authorization will be obtained when required.

6. ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have read and understood this form, have had the opportunity to ask questions, and voluntarily consent to receive the concierge nursing services described above.

I understand that this consent applies to the general nursing services arranged for me and does not replace any additional consent that may be required for a specific procedure or treatment.

Client Signature: _____

Date: _____

Authorized Representative (if applicable):

Relationship to Client: _____

Date: _____

Registered Nurse/Witness (if applicable):

Date: _____
