Patient Name: Or
Patient DOB: Patient
Patient #: Label
Date of Service:

Heart of the Rockies Regional Medical Center

CONSENT TO TREAT AND CONDITIONS OF SERVICE

1. **CONSENT FOR HEALTH CARE SERVICES:** I voluntarily request and consent to the rendering of health care services by the health care facility's employees, medical staff or others holding clinical privileges, including routine hospital services, diagnostic procedures, intravenous therapy, medications, anesthesia, injections and blood transfusions, and other services or procedures that may be administered to or performed on me under the general or special instruction of my treating health care provider or his or her designees. I understand that my treating health care provider will disclose to me the anticipated benefits and potential risks and complications associated with any medications, treatments, procedures or health care services provided to me. I understand that I have the right to discuss proposed procedures or treatments and their associated benefits, risks, and complications with my treating health care provider, and to consent to, or refuse such procedures or treatments. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me regarding the result of treatment or services rendered in this health care facility.
2. **LEAVING AGAINST MEDICAL ADVICE:** If I choose to leave the health care facility against or without the advice of a facility health care provider, I understand that my refusal could place my life or health at serious risk and I knowingly and voluntarily accept such risks and consequences and I will be asked to sign the "Statement of Patient Leaving Health Care Facility Against Medical Advice" form. I release Heart of the Rockies Regional Medical Center, its board of trustees/directors, officers, employees, clinical staff, contractors and agents from any and all liability for any consequences, injuries, harm and damages resulting from my refusal of recommended treatment or services against medical advice.
3. **ELECTRONIC ACCESS TO MEDICATION HISTORY:** I authorize the health care facility's providers and other care givers to have electronic access to my medication history which will enable them to view critical information about my past and current prescriptions. I understand that this will improve my safety and quality of care (e.g., preventing potentially harmful drug interactions or intolerances).
4. **FINANCIAL AGREEMENT/RESPONSIBILITY:** I agree, whether signing as agent or as patient, to assume full financial responsibility for and agree to pay all charges of the health care facility and treating health care providers rendering services and of HRRMC employed and contracted health care providers rendering services. All charges are due and payable upon presentation. Furthermore, should the account be referred to an attorney for collection, I agree to pay reasonable attorney fees and collection expenses. I understand financial counseling will be made available to me upon requests.
5. **ASSIGNMENT FOR DIRECT PAYMENT:** I hereby authorize payment to be made directly to the healthcare facility and my treating health care providers, not to exceed the amount of their regular charges, from any insurance or health care benefits, otherwise payable to me for health care services, goods and facilities provided. I understand there is no guarantee of reimbursement or payment from any insurance company or other payor and that I am financially responsible for all charges not paid for any reason by my health insurance or other payor within a time period the health care facility deems reasonable.
6. **COMMUNICATION REGARDING MY SERVICES:** By signing below, I authorize the health care facility and its affiliates to contact me by email, regular mail, text messages, telephone, including cellular, related to my healthcare services. The purpose of these communications might include but shall not be limited to appointment scheduling or reminders, financial obligations including payment reminders, delinquent notifications and patient billing information regarding any matter related to the referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto dialer or unattended dialer technology and/or prerecorded messages.
7. **PREAUTHORIZATION REQUIREMENTS:** I understand that it is my sole responsibility to comply with all requirements of any insurance or health benefit coverage plan under which I am relying for coverage of the health care facility's and treating health care providers' charges, including, but not limited to, any requirement to obtain authorization before a service is rendered.

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

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CONSENT TO TREAT AND CONDITIONS OF SERVICE

8. **MEDICARE OR MEDICAID REQUEST FOR PAYMENT (if applicable):** I certify that the information given by me in applying for payment of charges under the Medicare, Medicaid or other governmental medical assistance program is correct. I request that payment of authorized benefits under Medicare, Medicaid or other government program be made to the health care facility on my behalf for the health care facility's charges and the treating health care providers' charges for which the health care facility is authorized to bill in connection with its services.
9. **COLORADO GOVERNMENTAL IMMUNITY ACT:** Your medical care or treatment at Heart of the Rockies Regional Medical Center may be provided by individuals who are considered public employees by the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act, Article 10 of Title 24 of the Colorado Revised Statues, limits the amount of damages recoverable from public employees and entities, requires formal notice of claim, and places a 180–day time limit on the period for filing such notice of claim.
10. **PERSONAL PROPERTY:** I understand that the health care facility will not be responsible for the loss, destruction or theft of any personal property that I bring with me to the facility. I assume full responsibility for all my personal property. I release the facility from responsibility and liability for my personal items and valuables.
11. **RELEASE OF INFORMATION:** I understand that the health care facility and my treating health care providers are authorized (without my specific written authorization) to use and disclose my health information and medical records for treatment, payment, and health care operations purposes as described in the health care facility's **Notice of Privacy Practices,** including to any health care provider involved in any way in my care and to any person or entity which is or may be liable for all or part of the charges for services, goods or facilities provided to me. I understand that the health care facility will release of information needed for discharge planning, transfer, and follow-up purposes. I understand that following release of this information, the health care facility cannot control its confidentiality.
12. **NOTICE OF PRIVACY PRACTICES, PATIENT BILL OF RIGHTS AND ADVANCE DIRECTIVE INFORMATION:** ☐ I have **received** a copy. ☐ I have **declined** a copy.

ACKNOWLEDGMENT

I have read and fully agree to each of the statements in this form and sign below as my free and voluntary act, and have been offered a copy of it. I acknowledge that I am the patient or a person authorized by the patient or otherwise to sign and accept this agreement and consent on behalf of the patient.

Signature of Patient or Authorized Representative * Printed Name Representative's Legal Status/Authority Date/Time

** If signed by authorized representative, specify representative's legal status/authority (authorized representative's signature constitutes the persons' representation to HRRMC that he or she has the legal status and authority to sign on behalf of the patient).*

HRRMC may require documentation demonstrating such status/authority.

Consent obtained verbally via telephone (ONLY WHEN NECESSARY):

Name of Parent/Guardian or Authorized Representative Representative's Legal Status/Authority

Phone Number: ( ) Date and Time of Consent:

Healthcare team member obtaining telephone consent or when patient signs with an "X":

Signature Printed Name Date/Time

Witness to telephone consent:

Signature Printed Name Date/Time