NORTHWEST COLORADO HEALTH

CONDITIONS OF ADMISSIONS AND AUTHORIZATION FOR TREATMENT

1. Release of Information: The undersigned in consideration for the treatment to be given by the Northwest Colorado Health (The Agency) to client hereby agrees and expressly waives his/her privilege (and the privilege of the client being treated if other than the undersigned) to the confidentiality of medical records relating to this admission and any and all such medical treatment received relative to such admission including, without limitation, any psychiatric treatment , for the time period of this admission and agrees, understands and consents that all records generated by his/ her treatment and/or admission to the Agency (or treatment of one for whom the undersigned has legal responsibility or authority to execute this consent form) can be reviewed by any person or organization authorized by law or by a third party payor who may provide insurance payments to the Agency for the charges incurred for the services rendered to the patient and also expressly authorizes the Agency to release such records to such payor or to any person or organization authorized by law to review these records for any lawful purpose..
2. I authorize the release of the information on the immunization administration record sheet/approved Colorado certificate of immunization (front and back) to or from any of the following: health care provider, clinic, hospital, or public health agency providing care to the person named above; managed care organization or health insurer in which the person named above is enrolled as a member of or insured by; or school/child care in which the person named above is enrolled. I understand the information will be released for the specific purpose of verifying the immunization status of the person named above. The authorization will remain valid through the above-named person's entire school/college history. A photocopy of this authorization shall be as valid as the original.
3. Consent to Care: I am presenting myself for admission to the Agency and I voluntarily consent to the rendering of such care including diagnostic procedures and treatment by authorized agents and employees of the Agency and by its medical, dental and behavioral health staff, or their designees, as it may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my conditions. I realize that during the course of my care at the Agency, designated staff may make available to other health care providers, copies of my medical records for information relating to my care, and I consent to such releases. I consent that during the course of my treatment my external prescription history will be captured in my medical records.
4. If I am seeking or having family planning services today, I understand that covered family planning services include routine family planning visits to initiate, continue or discontinue a contraceptive method. Additional covered family planning services may include, but are not limited to, provision of contraceptive methods and pregnancy testing and counseling. I understand services are provided on a voluntary basis and that receipt of family planning services is not a prerequisite to receipt of any other services offered by Northwest Colorado Health. I understand that this agency may use a statewide database that makes my health information available to the state health department and other participating family planning programs in Colorado. The benefit to me is that I can change to another participating family planning clinic and that clinic can access the health information I have already shared.
5. If receiving behavioral health treatment, I understand the Agency offers primary care/behavioral health psychology services. I understand that the names and qualifications of the staff employed at the Agency that offer these services will be given to me if seen by a behavioral health specialist. I also understand that the practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Colorado Division of Registries. The Boards of Psychology and Social work can be reached at 1560 Broadway, Suite 1350 Denver, CO 80202. Telephone: 303-894-7800. As a recipient of behavioral health services, I also understand and am aware of the following information: (a) I have the right to get information from the behavioral health specialist about the type of therapy and techniques used, the estimated length of time of my treatment, and the fees; (b) I may get a second opinion from another therapist or decide to end my evaluation/treatment at any time; (c) In a professional relationship, as this one, sexual intimacy is never appropriate and illegal in the state of Colorado. If sexual intimacy occurs, I understand it should be reported to the Colorado Department of Agencies, Mental Health Section; (d) Generally speaking, the information I share during a therapy session is legally confidential, which means the therapist may not disclose the information without the my written consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPPA Notice of Privacy practices, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The mental Health Practice Act (CRS 12-43-101) is available at http://www.dora.state.co.us/mental-health/Statute.pdf.5 ; (e) If my clinical therapist is in training, I understand they work with their clinical supervisor work as a team to provide assessment, diagnosis, and treatment; (f) I understand my therapist may discuss my evaluation and treatment with referring and treating medical providers and care givers.

Furthermore, I am aware that documentation of my visits with the behavioral health team will be made in the Agency's electronic medical record.

6. If receiving dental services at the Agency, my signature acknowledges consent to treatment and that any diagnosis or assessment is for the purpose of determining necessary dental services only and that it is recommended by the American Dental Association, or any successor organizations, that a thorough dental examination be performed by a dentist twice each year per the Dental Practice Law of Colorado. I also understand that the practice of Registered Dental Hygienists is regulated by the Colorado Dental Board. The Colorado Dental Board can be reached at 1560 Broadway, Suite 1350 Denver, CO 80202. Telephone: 303-894-7800 and Fax: 303-894-7764. To file a complaint, use the Online Services Complaint Submission to the Division of Professions and Occupations found on https://www.colorado.gov/pacific/dora/DPO_File Complaint. A hard copy of the Healthcare Related Professions Complaint Form may be found on this website and submitted to the address listed above, in addition to any documentation
7. Treatment by a student: Agency participates in the clinical training of medical / dental / behavioral health students. This program provides the necessary experience and required clinical hours that may be required for graduation in the student's desired field of practice. A licensed provider from Agency will be overseeing your care in order to assure the best possible treatment. Any questions or concerns on your part will be addressed at once by the supervising provider. You have the right to refuse treatment at any time during this appointment and be rescheduled with another provider.
8. Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the Agency and any other licensed provider for application on patient's bill, and it is agreed that the Agency and/or licensed provider may receipt for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment.
9. Financial Agreement and Payment Guarantee: Both undersigned patient and the guarantor(s) agree that in consideration of the services to be rendered to the patient, they hereby individually obligate themselves to pay the charges of the Agency and any other licensed provider in accordance with the regular rates and terms of the Agency and any other licensed provider. **You may receive a bill from a non-participating provider associated with the Agency.** Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent account bear interest at the legal rate.
10. For Medicare/Medicaid Beneficiaries Only: I certify that the information given by me in applying for payment under Titles XVII & XIX under social security Act is current. I request that payment of authorized benefits be made on my behalf for any services furnished me by or in the Agency, including physicians' services. I authorize any holder of medical or other information about me to release to the health care financing administration and agents any information necessary to determine these benefits or related services.

The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. All guarantors certify that they have read the foregoing and accept its terms.

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Patient **Date**

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Guarantors **Relationship to Patient**

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Witness