COLORADO MOUNTAIN MEDICAL - CONSENT TO TREAT

CONSENT TO MEDICAL EXAMINATION AND TREATMENT: I consent to examination and treatment to be provided by Colorado Mountain Medical, L.L.C. ("CMM") doctors, physician assistants, nurse practitioners, and professional and nursing staff. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, provided under the general and special instructions of my physician or health professional. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made regarding the result of examination or treatment. I understand that CMM may communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

CONSENT TO BEHAVIORAL HEALTH SERVICES: I consent to behavioral health (BH) care and treatment performed by the BH providers at CMM which may include screening, assessment, therapy, and consultation with other CMM staff. I understand the risks and benefits of BH services, including the risks associated with declining a specific service. I understand that I can ask about alternative services, request a second opinion, actively participate in treatment, and/or revoke this consent at any time. I understand that CMM BH staff are not available by email or text. CMM refers to the Hope Center for emergencies. In the event of a BH crisis, contact 911 or the Hope Center at 970-306-4673. In order to receive BH care services, I will be required to sign a separate Behavioral Health Disclosure and Consent for Treatment.

FINANCIAL AGREEMENT: I agree to pay all bills promptly and in accordance with CMM's rates and terms. At the time of the visit, I will pay any co-payments or deductible amounts that are due, and I will pay the balance due after payment by any insurer or third-party payer. I understand CMM may charge for missed appointments unless the appointment is cancelled 24 hours in advance. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at 1.5% per month or the highest permissible legal rate.

ASSIGNMENT OF BENEFITS: I assign and authorize direct payment to CMM of all insurance and health plan benefits payable for the services provided by CMM. I agree that the insurer or plan's payment pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law.

HEALTH PLAN OBLIGATION: CMM maintains a list of health plans with which its contracts. A list of such plans is available upon request at the reception desk. CMM has no contract, express or implied, with any plan that does not appear on the list. I agree to pay CMM its full rates for all services I receive from CMM if I belong to a plan that does not appear on the above-mentioned list.

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGMENT OF RECEIPT: I acknowledge receiving CMM's "Notice of Privacy Practices," which provides information about how CMM may obtain, use and disclose my protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change and you may obtain a copy of the revised notice by calling our office. If you have any questions about our "Notice of Privacy Practices," please ask at the reception desk.

I certify that I have read the foregoing and I am the patient, the patient's legal representative, or otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

Signature: _____ Date: _____

Print name: _____
If signed by other than the patient, indicate relationship to the patient: _____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT:

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above and to cover any financial responsibility not covered by the patient or a third party payor.

Signature: _____ Date: _____
(Financially responsible party)

Print name: _____ Telephone Number (_____)_____