

**Permission To Treat**

**Permission To Treat:** I, as a patient, parent, or agent of the patient, voluntarily request and consent to the rendering of healthcare services. By Telluride Hospital District, DBA Telluride Regional Medical Center (*TRMC*) and *TRMC*-Primary Care.

**Education:** I authorize observers to be present during treatment and any treatment to be recorded and/or photographed and saved for educational and training purposes.

**Payment of Services Agreement:** By signing this form, I acknowledge and agree that I am financially responsible for paying all costs and charges of the facility in accordance with the facility Charge Master rates, which rates are hereby expressly incorporated by reference as the price term of this assistance for which I am determined to be eligible for. Additionally, I also agree to pay for radiology services, provided by *Mountain Radiology*, *LLC*, and/or pathology, and laboratory services provided by *LabCorp*, *Myriad*, *Ambry Genetics*, and/or *University of Utah Dept of Dermatology*, which are billed separately, should these services be deemed necessary in the opinion of the medical provider at *TRMC*. Bills for all services shall be due and payable upon receipt. If charges are not paid within 90 days of the first statement, I understand that I may be liable for collection agency expenses, including reasonable attorney fees, in the event action is brought against me for failure to pay charges as billed by *TRMC*, *Mountain Radiology*, *LabCorp*, *Myriad*, *Ambry Genetics*, or the *University of Utah Dept of Dermatology*.

**Medicare Title XVIII and Medicaid Title XIX:** I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

**Authorization for Release of Information:** I hereby authorize the release of medical records to any person or entity that is liable under a contract for payment of any charges incurred by me as part of medical treatment provided by *TRMC*, or any medical provider for the purpose of continued care.

**Authorization to Download Medication History:** I hereby authorize the download of my medication history into my medical record via Pharmacy Benefit Managers.

**Insurance Claims:** If you have presented us with insurance information that has an address within the United States and is not out of state Medicaid, we will submit the claim on your behalf.

**Assignment of Insurance Benefits:** I hereby authorize any third party responsible for any portion of the patient’s covered medical services to make payment directly to *TRMC* and/or *Mountain Radiology LLC*, and/or *LabCorp* and/or *Myriad*, and/or *Ambry Genetics*, and/or the *University of Utah Dept of Dermatology*. I acknowledge that this assignment of benefits is irrevocable and assigns to the medical providers all rights under my insurance policies. I understand that I am financially responsible to *TRMC* and/or *Mountain Radiology LLC*, and/or *LabCorp* and/or *Myriad*, and/or *Ambry Genetics*, and/or the *University of Utah Dept of Dermatology* for charges not covered by any insurance or third-party payor.

**Health Information Exchanges:** I hereby authorize the download and upload of my medical record via health information exchanges such as QHN (Quality Health Network), Common Well and Care Quality.

**Governmental Immunity Notice:** Medical Care and other health care at the Telluride 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 the Title 24 of the Colorado Revised Statutes, limits the amount of damages recoverable from public employees and entities, requires a formal notice of a claim, and places a 180-day time limit on the period for filing such notice of claim.

**Telemedicine:** I consent to *TRMC* arranging a telemedicine consult if it is necessary for my medical condition.

**THE UNDERSIGNED HEREBY CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE ABOVE STATED CONDITIONS OF CONSENT AND HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.**

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Signature of Patient or Responsible Party Today’s Date

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Printed Name Relationship Phone

**If you are signing on behalf of the patient and are not the responsible party:**

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Signature Print Name Relationship to Pt Date

Reason Pt Cannot Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_/\_\_/\_\_