Aspen Valley Hospital

Consent for Hospital Services: Consent is given to Hospital, its contractors and its employees to provide services and administer physician orders. Certain procedures require a separate consent. Your physician is responsible for explaining medical or surgical procedures. Your signature authorizes observers to be present during treatment/surgery for purposes of their medical training and education.

Personal Valuables: The Hospital is not responsible for personal property which is not deposited in the Hospital safe.

Authorization to Release Information: Your signature authorizes the Hospital and any physician rendering service to release medical and other information about you, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative. Your signature authorizes viewing of medical records by accrediting and regulating bodies for the purpose of evaluating patient care and/or services.

- Quality Health Network (QHN): Your medical information has been made available to the regional health information exchange (QHN) where only authorized providers in the community may access this information to provide continuing care to you.
- Aspen Valley Medical Foundation (AVMF): Your demographic data (no health information) is provided to the Aspen Valley Medical Foundation for the sole purpose of fund raising on behalf of the hospital. If you desire not to have your information available to the Foundation, please submit a written statement notifying us.

Assignment of Benefits: Your signature authorizes payment of benefits, including insurance benefits, otherwise payable with respect to you, the Hospital, or any physician rendering service. You agree to assist in the processing of claims for benefits.

Medicare Authorization: You certify the information you have given in applying for payment under Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information about you to release to the Social Security Administration and Healthcare Financing Administration, or its intermediaries or carriers any information needed for this or a related Medicare claim. You request the payment of authorized benefits be made on your behalf to the Hospital or any physician rendering service during your treatment.

Financial Responsibility: You jointly and severally agree to pay for Hospital services and accommodations and physician services. You understood and agree Hospital charges not paid may be placed with an attorney or collection agency, and that reasonable attorney fees and/or open account interest charges assessed are your responsibility. To the extent not expressly prohibited by applicable law, you jointly and severally agree to pay all Hospital charges not paid in full to the Hospital by a third-party payer.

Note: Physicians, including but not limited to, Radiologists, Anesthesiologists, Certified Registered Nurse Anesthetist and Pathologists provide services in our Hospital and are not employees or agents of Aspen Valley Hospital.

Disclosure of Governmental Immunity: Medical care or treatment at Aspen Valley Hospital 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 Statutes, limits the amount of damages recoverable from public employees and entities, requires formal notice of claim, and places 180 day time limit on the period for filing such a notice of claim.

Consent for Purposes of Treatment, Payment & Healthcare Operations: I consent to the use or disclosure of my protected health information by Aspen Valley Hospital for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Aspen Valley Hospital. I understand that diagnosis or treatment of me by Aspen Valley Hospital may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the Hospital. Aspen Valley Hospital is not required to agree to the restrictions that I may request. However, if Aspen Valley Hospital agrees to a restriction that I request, the restriction is binding on Aspen Valley Hospital.

I have the right to revoke this consent, in writing, at any time, except to the extent that Aspen Valley Hospital has taken action in reliance on this consent. My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Aspen Valley Hospital's Notice of Privacy Practices prior to signing this document. Aspen Valley Hospital's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Aspen Valley Hospital. The Notice of Privacy Practices for Aspen Valley Hospital is also posted in the Main Lobby and the Emergency Department Entrance. This Notice of Privacy Practices also describes my rights and Aspen Valley Hospital's duties with respect to my protected health information.

Aspen Valley Hospital reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the Admitting Department at 970-544-7350, or by requesting a revised copy be sent to me in the mail.

By placing your signature, you certify the foregoing statements and consents have been read and understood; and, certify you are the patient or duly authorized as the patient's representative to execute and accept the terms of this consent. I have received the Patient's Rights and Responsibilities; and, an Important Message from Medicare, if applicable.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Description of Personal Representative's Authority | Witness

Aspen Valley Hospital 970-925-1120
Medicare Fraud 800-525-6519
Colorado Medical Review Association 800-727-7086

Revised: 03/04/10