Name, MR#, Pat#, DOB

DENVER HEALTH AND HOSPITAL AUTHORITY

HOSPITAL GENERAL CONSENT FOR TREATMENT AND TERMS RELATING TO PAYMENT ("CONSENT")

CHANGES TO THIS CONSENT: I UNDERSTAND THAT I MAY NOT CROSS OUT ANYTHING ON THIS CONSENT. IF I DO, DENVER HEALTH MAY REFUSE TO TREAT ME UNLESS I HAVE AN EMERGENCY. I UNDERSTAND DENVER HEALTH IS NOT REQUIRED TO FOLLOW ANY CHANGES THAT I MAKE.

DEFINITIONS: The "Denver Health and Hospital Authority" ("Denver Health") includes all of Denver Health's facilities including the hospital campus and neighborhood, school- based and mobile clinics and satellite offices and ambulances. "Healthcare" includes routine hospital services, diagnostic tests, intravenous therapy (therapy given through my vein), medications, anesthesia, injections, blood transfusions counseling and other health services. Health care may be given in the hospital (an "inpatient") or in a clinic ("outpatient").

CONSENT FOR TREATMENT: I would like to receive healthcare from Denver Health's providers and others allowed to treat me at Denver Health either as an inpatient or an outpatient. Outpatient care may be in person or via telehealth (seeing my provider by video). If I use telehealth, I understand that Denver Health is protecting my privacy by using an encrypted system that follows the Health Insurance Portability and Accountability Act (HIPAA). However, I know there are risks to telehealth including interruptions, unauthorized access, and technical problems. I understand that the provider or I can discontinue the telehealth visit if it is felt that the video connection is not good for my situation. Denver Health is a teaching hospital and some of my care may be given by providers in training who may not be employees of Denver Health. I have a right to ask questions and talk about my treatment with my providers, and I have a right to refuse any treatment. If I decide to leave Denver Health as an inpatient before my treatment is finished, I will talk to my provider(s) before leaving. If I leave and my provider thinks it's not good for me to do that, my leaving will be a Discharge Against Medical Advice (AMA) in Denver Health's records. If I leave AMA Denver Health will not be responsible for anything that happens to me because I did not follow advice. I may be asked to sign other consent forms if I have a procedure or take part in a research study. I understand that the practice of medicine and surgery is not an exact science and that my care may involve risks of injury and even death. I know that no guarantees or promises have been made to me about the outcome of my treatment.

IMAGES AND OBSERVATION BY OTHERS: My providers may wish to have photos, videos and other images taken of me to help with my care, to identify me or for provider education. Photos or videos that identify me will not be released outside of Denver Health without my consent, unless required by law. I have a right to tell my providers that I do not wish to have photos, videos or other images taken of me. Providers who are students or are in training and who are not providing my care, may wish to watch my care for training and education. I have a right to tell my providers that I do not wish to have others watch my care for training and education.

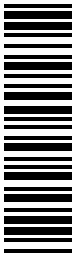
DISCLOSURE OF INFORMATION: I allow Denver Health and my providers to give information from my records for treatment, payment and healthcare operations purposes (including healthcare exchanges) as written in Denver Health's Notice of Privacy Practices and for my care when I leave Denver Health and as required by law. I allow Denver Health and my providers to give information from my records to any provider involved in my care and to any party that may be responsible for payment of my Denver Health bill, including insurance companies, financial aid programs ("aid programs"), employers in workers' compensation matters (where I might have been hurt at work), and the person that caused my injuries and their lawyers and insurers. I understand this information may be shared electronically.

I acknowledge that I can change my participation status, by requesting to "OPT OUT", at any time by writing to: Denver Health and Hospital, ATTN: Health Information Management Department MC0296, 301 W. 6th Avenue, Denver, CO 80204.

I understand that once such information is disclosed, Denver Health is not responsible for the re-disclosure of my information.

HEALTH INSURANCE AND FINANCIAL AID PROGRAMS: Denver Health is a hospital and provider (like my doctor) facility so I may receive two separate bills for my care (one from the hospital and one from my doctors). I understand there is no promise that my insurance or an aid program will pay my Denver Health bill and I must pay any bill that is not paid by insurance or an aid program. I agree to give Denver Health information about my health insurance and about anyone that caused the injuries that made me come to Denver Health. I promise that all of the information I give when applying for benefits under medical assistance (Medicaid) will be correct. I understand that I may have to get my health insurance or aid program to approve my care so the insurance company or program will pay my Denver Health bill. I UNDERSTAND THAT I MUST PAY ANY DENVER HEALTH BILLS THAT ARE NOT PAID BY INSURANCE OR AN AID PROGRAM BECAUSE I DID NOT PROVIDE DENVER HEALTH WITH INFORMATION TO FILE A CLAIM, OR BECAUSE I DID NOT GET INSURANCE APPROVALS, OR MAYBE BECAUSE DENVER HEALTH DOES NOT HAVE A CONTRACT WITH MY INSURANCE COMPANY (OUT OF NETWORK), IF ALLOWED BY LAW. I agree to pay all co-payments, deductibles and other charges not covered by insurance or an aid program, unless payment is not required by law or written agreement with my insurer. I understand that I must pay for any care not covered or discounted by insurance or an aid program because the care is not considered medically necessary, like cosmetic surgery.

ASSIGNMENT OF BENEFITS AND CLAIMS: I assign or give my rights to Denver Health, up to the amount of my medical expenses, any and all benefits, damages and settlements that I may be entitled to receive from health, homeowner's, business owner's, workers' compensation, rehabilitation and disability insurers. Denver Health may, but does not have to, sue the responsible person to recover my healthcare expenses in my name or in the name of Denver Health. I agree to help Denver Health in its claim in any reasonable manner requested. I give to Denver Health an irrevocable, limited, power of attorney to sign for me any release, consent, authorization or other document requested by an insurance company in order to pay Denver Health. I wish to provide for the payment of my healthcare expenses in the event of my death and therefore, to the extent permitted by law, allow Denver Health to name a Personal Representative to file and handle my estate, pay claims and other obligations, and make a claim for expenses against anybody that caused my injuries. Colorado law allows Denver Health to file hospital liens (claim on property) against any insurance available to pay my healthcare expenses. Denver Health may include my name, social security number, and date of birth in any hospital liens that Denver Health files on my account.



DELINQUENT ACCOUNTS: I understand that if Denver Health is slow in trying to collect my bill or gives me extra time to pay, that does not forgive my need to pay. If my bill is overdue, Denver Health may refuse to provide care until my bill is paid, unless not allowed by law such as an emergency. Interest on unpaid bills may be charged at the highest rate allowed by law. If Denver Health has to sue me to collect my bill, Denver Health may file such lawsuit in the District or County Courts of Denver, Colorado. I agree that Denver Health can provide my medical and billing records in any such collection lawsuit and related matters. In the event that DHHA wins in court, I agree to pay to Denver Health its reasonable lawyer's fees, court costs, and expenses of collection. I allow Denver Health to obtain copies of my credit bureau reports and to obtain from anybody any information about me that is reasonably necessary for collection purposes. I consent to be contacted by regular mail, email, text, or telephone (including wireless/cell number) regarding any matter to my account(s). This consent applies to all Denver Health providers and/or any company working for Denver Health. This consent includes any updated or additional contact information that I may provide, and includes phone calls that employ auto-dialer technology and prerecorded messages. If I want to cancel this consent, I agree to provide notice of that by contacting Denver Health Patient Financial Services.

BEHAVIOR EXPECTATIONS: I understand that if I am physically or verbally threatening, hostile, or violent while at Denver Health, I may be refused any further care unless it is an emergency. I understand that Denver Health Security and the Police will be called and that I might be prosecuted. I also understand that while admitted for treatment to the hospital as an inpatient at Denver Health, I may not leave my hospital room to go outside.

NON-SMOKING POLICY: I understand that I am not allowed to smoke, use any tobacco products including e-cigarettes or vaping on or next to Denver Health and any of its locations. I cannot leave Denver Health to smoke during my inpatient hospital admission.

CONTRABAND AND PERSONAL PROPERTY: I understand that I may not keep any weapons, explosives, drugs, marijuana, alcohol or other items not allowed by law or hospital policy (contraband) while I am at Denver Health. Should Denver Health suspect I have any contraband, Denver Health has my permission and may search my clothing, personal belongings and area of care. If any contraband is found, Denver Health may take possession of the items and dispose of them in any manner allowed by law. Denver Health may also notify Law Enforcement. I understand that I should not have any money or other valuable property while at Denver Health. Denver Health is not responsible for damage to, theft, or loss of my money and other property.

GOVERNMENTAL IMMUNITY: Medical care or treatment at Denver Health may be given by people who are considered public employees by the Colorado Governmental Immunity Act (Article 10 of Title 24 of the Colorado Revised Statutes). That law limits the amount of money I can receive if I make a claim or file a law suit against Denver Health or its employees. I understand that the Colorado Governmental immunity Act requires that I, or my lawyer, file a formal notice of claim against Denver Health. That notice must be filed within 182 days of finding out I have an injury or as stated by the Governmental Immunity Act.

DURATION OF CONSENT: I understand that this Consent will be active for as long as I receive healthcare at Denver Health, or until I cancel this Consent in writing. If I cancel this Consent, it will be cancelled only as to future care and not as to care I already received. If I have already received care but could not sign this Consent until now, I agree that this Consent will apply to the care that I have already received. I may be asked to sign additional Consent forms on a yearly basis, upon each admission to the hospital or as required by hospital policy.

AUTHORIZED REPRESENTATIVE/GUARANTOR: If I am not the patient and I sign this Consent as the patient's Authorized Representative, I have full legal authority to sign on behalf of the patient and I understand that Denver Health is relying upon the truthfulness of this representation. I understand that both the patient and I will be fully bound by this Consent. I understand that, by signing this Consent I GUARANTEE AND AGREE TO MAKE PAYMENT OF ALL OF THE PATIENT'S HEALTHCARE EXPENSES, and that if payment is not made, the patient and I will be subject to the remedies provided in the paragraph entitled, Delinquent Accounts, above.

ACKNOWLEDGMENT: I acknowledge that I have read this Consent and understand and agree with what it says. Any questions that I had about this Consent have been answered. No one has forced me to sign this Consent against my will. I have either received or have been offered a copy of this Consent.

I CERTIFY THAT THE INFORMATION I PROVIDE BELOW WILL BE TRUE AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE INFORMATION TO OBTAIN HOSPITAL OR MEDICAL CARE IS A CLASS 1 MISDEMEANOR PUNISHABLE UPON CONVICTION BY UP TO EIGHTEEN (18) MONTHS IMPRISONMENT OR A $5,000.00 FINE OR BOTH (C.R.S., §§18-13-124 and 18-1.3-501). I UNDERSTAND THAT IF I PROVIDE FALSE, MISLEADING, OR INCOMPLETE INFORMATION AS TO MY IDENTITY OR RESIDENCE ADDRESS OR WHEN APPLYING FOR A FINANCIAL AID PROGRAM, DENVER HEALTH MAY REPORT ME TO LAW ENFORCEMENT AND MAY REFUSE TO PROVIDE ME WITH NON-EMERGENCY-RELATED HEALTHCARE.

For care that I am receiving today as an outpatient if it applies, I acknowledge that I am being seen in a Denver Health urgent care clinic _____ or emergency department _____. (Please initial one) Emergency services are for more severe conditions and often result in higher out of pocket costs for the patient.

If you are signing this Consent as the patient's Authorized Representative, put an "X" in the box that shows your legal relationship to the patient:

☐ patient's parent ☐ patient's legal custodian ☐ patient's conservator ☐ power of attorney

☐ patient's legal guardian ☐ patient's foster parent ☐ patient's spouse

☐ patient's child over the age of 18 ☐ other legal relationship: _____

_____

Patient Signature/ Date (mm/dd/yy) Time (00:00)

Print full legal name of Patient: _____

_____

Authorized Representative Signature/ Date (mm/dd/yy) Time (00:00)

Print full legal name of Authorized Representative: _____

_____

DHHA Witness Signature/ Date (mm/dd/yy) Time (00:00)

PRINT name of DHHA witness: _____

OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition.

☐ Patient is unable to sign due to condition; however, did provide Oral consent.

☐ Patient is a minor. Consent was obtained by telephone from _____, who is the patient's:

_____.

☐ Patient refused to sign.

_____

DHHA Staff Person's Name (Printed)