TELLURIDE
REGIONAL MEDICAL CENTER

PATIENT'S NAME	
DATE OF BIRTH	/ /

PERMISSION TO TREAT AGREEMENT

PERMISSION TO TREAT: I hereby authorize Telluride Hospital District, DBA Telluride Regional Medical Center and TRMC-Primary Care to provide treatment to me or my minor child.

EDUCATION: I authorize observers to be present during treatment for purposes of medical training and education.

PAYMENT OF SERVICES AGREEMENT: I agree to pay for medical services provided by Telluride Regional Medical Center (TRMC). I also agree to pay for Radiology Services, provided by Western Colorado Radiological Associates, P.C. (WCRA), and/or pathology, and laboratory services provided by LAB CORP, Myriad, Ambry Genetics, 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 30 days of receipt, 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, WCRA or LAB CORP, Myriad, Ambry Genetics, or 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.

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 WCRA and/or LAB CORP and/or Myriad, and/or Ambry Genetics, and/or 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 further understand that I am financially responsible to TRMC and/or WCRA and/or LAB CORP and/or Myriad, and/or Ambry Genetics, and/or 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, 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 Title 24 of the Colorado Revised Statutes, limits the amount of damages recoverable from public employees and entities, requires a formal notice a claim, and places a 180 day time limit on the period for filing such a 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 HE/SHE HAS READ AND UNDERSTANDS THE ABOVE STATED CONDITIONS OF CONSENT AND HAS RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient or Responsible Party Signature | Date

_____ _____ _____

Print name | Relationship to Patient | Phone

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

_____ _____ _____ _____

Signature | Print name | Relationship to Patient | Date

Reason patient cannot sign: _____ Witness _____ Date _____

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