

## DIVERSIFIED SERVICES CONSENT FOR ADMISSION

### LOCATION

- Vail Valley Medical Center
- Vail Valley Obstetrics Gynecology
- Vail Institute for Aesthetic and Reconstructive Surgery
- Avanti Cardiology

- Northstar Urology
- Mountain Surgical Associates
- EagleCare Medical Clinic
- Shaw Regional Cancer Center
- Other: \_\_\_\_\_

### CONSENT TO MEDICAL, SURGICAL, AND / OR PSYCHIATRIC PROCEDURES:

The undersigned consents to the procedures which may be performed during this treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, rehabilitation, medical or surgical treatment, psychiatric procedures, or anesthesia or transfusion rendered to the patient under general and special instruction of the patient's physician or psychiatrist.

### LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS, SURGEONS, PODIATRISTS, RESIDENTS, AND STUDENTS:

You are under the care and supervision of your attending physician, podiatrist or dentist, and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician, podiatrist or dentist. Certain aspects of your care may be performed by a medical student or resident. Medical students/residents are not employees or agents of the hospital. The activities of medical students/residents are performed under the supervision of an attending physician, not the hospital, and are in furtherance of their graduate medical education. If you object to any aspect of your care being performed by a student/resident, you must make such an objection known to your attending physician immediately. Absent such objection, you will be deemed to have consented to the participation of such student/resident(s) in your care.

Certain aspects of your care may be performed by one or more physicians who are "public employees," as that term is defined in the Colorado Governmental Immunity Act, C.R.S. § 24-10-101, et seq. As such, their liability for claims that you may make relating to the care that they provide to you may be limited by the terms of the Governmental Immunity Act. If you object to any aspect of your care being performed by physicians who are subject to the Governmental Immunity Act, you must make such an objection known to your attending physician immediately. Absent such objection, you will be deemed to have consented to the participation of such physicians in your care.

It is the responsibility of the patient's physician, podiatrist or dentist to obtain your informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to you under the general and special instructions of the physician, podiatrist or dentist. Any questions concerning the nature or results of any examination or treatment should be directed to your attending physician, podiatrist or dentist.

### POLICY STATEMENT ON FINANCIAL AGREEMENT:

The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay all actual attorneys fees and collections expenses. It is understood that financial liability for all services deemed non-covered by insurance will be my sole financial responsibility and are to be paid at the time of services or within thirty (30) days upon receipt of my Explanation of Benefits.



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### POLICY STATEMENT ON INSURANCE BENEFITS:

I understand that health insurance is an agreement between my insurance company and me to pay a specified amount for medical care. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the facility of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services at rate not to exceed the regular charges. It is agreed that payment to the physician pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. Any precertification of insurance benefits is the patient's sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient of all services furnished by WMC Diversified Services is authorized to bill in connection with its services. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

### RELEASE OF MEDICAL RECORDS:

I authorize the release of medical information to my primary care or referring physician, if needed to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to WMC Diversified Services. The undersigned authorizes facility to obtain past prescription history.

Please list the names of persons, if any, whom we may inform about your medical conditions and diagnosis: \_\_\_\_\_

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Please list the names of persons, if any, whom we may inform about medical conditions IN AN EMERGENCY: \_\_\_\_\_

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### PRIVACY POLICY:

I undersigned and have had full opportunity to read and consider the contents of this Consent Form and have received a copy of your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient / Parent / Guardian / Conservator / Agent \_\_\_\_\_ Date: \_\_\_\_\_

If other than patient, indicate relationship \_\_\_\_\_ Date: \_\_\_\_\_

