

CONSENT FOR HOSPITAL OR OUTPATIENT CARE: I hereby voluntarily consent to the rendering of healthcare services by National Jewish Health employees, medical staff or others holding clinical privileges, including, routine hospital services, diagnostic procedures, intravenous therapy, medical treatment, and other hospital care and services. These services may be rendered under the direction and supervision of the medical staff of National Jewish Health. If the patient is initially seen as an outpatient and the attending physician determines during the course of such outpatient care that the patient's condition would be best managed on an inpatient basis, I hereby consent to such inpatient admission and agree that the terms of this agreement are in effect for inpatient admission. If the patient is initially admitted as an inpatient and it is determined that the patient's care can be managed in an outpatient setting, I hereby consent to such services. I understand that I have the right to discuss proposed procedures or treatments with the physician and to consent to, or refuse such procedures or treatments. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the results of examination or treatment at National Jewish Health.

EMERGENCY TREATMENT: I hereby authorize any medical or surgical treatment deemed necessary by the medical staff of National Jewish Health, should that care become necessary in the event of an emergency when any delay in rendering care could result in irreparable harm to or death to the patient. I understand that because National Jewish Health is a specialty hospital and that it does not routinely provide surgical and general medical care, the patient may be transferred to another local hospital deemed by the medical staff of National Jewish Health to have the appropriate facilities for treatment. I hereby give consent to any such transfer.

WAIVER OF RESPONSIBILITY FOR DISCHARGE AGAINST OR WITHOUT MEDICAL ADVICE: If I choose to leave the healthcare facility against or without the advice of my physician, I hereby release the physician, National Jewish Health, its agents and employees from all liability for any ill effects which may result.

RELEASE OF INFORMATION: I hereby authorize National Jewish Health and its physicians and employees to release information from the patient's medical records for treatment, payment and healthcare operations purposes as described in the National Jewish Health Notice of Privacy Practices, including to any healthcare provider involved in any way in the care of the patient and to any person or entity which may be liable for all or part of the charges for services, goods or facilities provided to the patient. I also authorize the release of information needed for discharge planning, utilization reviews, transfer, follow-up and other purposes as the physicians and others providing care at National Jewish Health deem appropriate. I understand that following the release of this information, the health care facility cannot control its confidentiality. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

PERSONS BOUND BY THIS AGREEMENT: If appropriate, the term "Patient" as used herein shall mean the Patient's legal representative, including, but not limited to, the Patient's parent, conservator, or guardian.

Please Initial: _____ I hereby certify that I have full authority to consent for hospital or outpatient care, and that consent is not required from anyone else.

PRE-AUTHORIZATION: I understand that it is my sole responsibility to obtain all insurance referrals and to provide all information necessary to obtain any pre-authorizations required by my insurance company. I further understand that it is my sole responsibility to comply with all requirements of any insurance or medical/hospital coverage plan under which I am relying for coverage of the National Jewish Health charges.

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct. I authorize release of information needed to act on this request. I request that payment of hospital and physician Medicare and Medicaid benefits, if applicable, be made on my behalf.

THIRD PARTY ASSIGNMENT/FINANCIAL AGREEMENT: I, the undersigned, hereby represent and agree as follows: I am responsible for full payment of all National Jewish Health bills, and I must pay amounts within a time period National Jewish Health deems reasonable. I understand that National Jewish Health may bill insurance companies or other third-party payers on my behalf, but that there is no obligation to do so. I hereby authorize payment to be made directly to



Patient Label

ON001
Admission Record_CC

Consent to Treatment

National Jewish Health, from any insurance or health care benefits, otherwise payable to me for health care services, goods and facilities provided by National Jewish Health. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer and that I am financially responsible for all charges not paid for any reason, including but not limited to charges that are non-covered, not billed, not collected, or otherwise not paid by insurance companies or other third-party payers. No extensions, forbearances or delays in enforcing any rights of collection of charges shall in any manner release or affect my responsibility therefore. I understand that unpaid balances, not otherwise paid by insurance, over ninety days old will include a delinquent or interest charge at the rate of one-and-one-half percent (1.5%) per month or the maximum rate allowed by law.

2) I agree to pay all costs and expenses, including, but not limited to, reasonable attorney's fees and costs incurred by National Jewish Health in collecting any amounts not otherwise paid by insurance.

3) I hereby assign to National Jewish Health any and all claims and causes of action of any kind whatsoever against an insurance company or other third party payer or against any other person or entity for payment or reimbursement for services, goods or facilities provided by National Jewish Health. I understand that this assignment is given to permit National Jewish Health to pursue these claims on my behalf as a courtesy to me and that National Jewish Health is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation and agreement to pay National Jewish Health's charges. I understand that this assignment takes effect upon notice by National Jewish Health that it intends to exercise these rights.

4) You have the right to restrict us from sending protected health information to your health insurance carrier. If you request National Jewish Health to restrict disclosure of your health care treatment for payment purposes for any service provided by National Jewish Health to your insurance carrier, National Jewish Health requires that you pay the estimated balance in advance. You will be billed for additional balances beyond the estimate, or refunded any overpayment after services are provided. Do you wish National Jewish Health to restrict the disclosure of health care information to your health care insurance carrier? (Please initial your choice) ____ Yes ____ No **If you indicated yes, you must also complete the Request to Restrict Protected Health Information from Disclosure to Insurance Carrier form (HIP-028) in the Health Information Management Department, K104.**

5) I consent to be contacted by regular mail or by telephone (including a cell phone) regarding any matter related to my account by National Jewish Health or any entity to which National Jewish Health assigns my account(s). I also consent to the use of any updated or additional contact information that I may provide, by National Jewish Health or any entity to which National Jewish Health assigns my account(s),

WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I should not keep any money or valuable property with me while at National Jewish Health. I understand that National Jewish Health does not assume responsibility for the loss or damage to the patient's personal property.

MANDATORY DISCLOSURE STATEMENT: While I or my minor child is a Patient at National Jewish Health, I may be seen by a licensed or unlicensed psychologist, counselor, or medical or clinical social worker who may assist me with counseling or discharge planning services. I have been informed that Colorado Law requires that institutions present the following rights: Any Patient who is seen by a licensed or unlicensed psychologist, counselor, or social worker in the State of Colorado is entitled to receive information about that person's degrees and credentials; the methods, techniques and duration of therapy,

if known; and fee structure. A Patient may seek a second opinion or terminate therapy at any time. Sexual intimacy within a professional relationship is never appropriate and should be reported to the State Grievance Board. Information provided by a Patient in counseling is generally confidential, and exceptions that arise during therapy will be identified and discussed.

USE OF INFORMATION IN DIAGNOSIS AND TREATMENT: The Patient hereby authorizes National Jewish Health to take photographs, make sound recordings, or record videos to use in your treatment and diagnosis. Tissues, parts, or body samples resulting from any procedure the Patient undergoes at National Jewish Health for the purposes of diagnosis or treatment may be preserved; used for scientific or teaching purposes; and/or otherwise disposed.



Patient Label

ADVANCE DIRECTIVES: Please indicate below if the patient has an advance directive in place. If so, please provide a copy of the advance directive to National Jewish Health for inclusion in the medical record.

Yes I have an advance directive in place
 No I do not have an advance directive in place

Date Time

Signature of Insured

Witness Signature

Patient Signature

Parent/Guardian (if Patient is
Minor/Mentally Impaired

Relationship to Patient



Patient Label