TO OUR PATIENTS AND FAMILIES

Thank you for choosing Children's Hospital Colorado (CHCO).
We consider families to be essential participants in their child's care and we wish to support and respect their needs while in our hospital.

We want you to understand your rights and responsibilities as families and patients at CHCO. Your signature on this form provides consent for treatment and payment, and acknowledges receipt of other general information.

If you have questions, please ask your provider or contact our Patient Relations Program at 720.777.1010.

As a parent/legally authorized representative of a patient at CHCO, you are the patient's "personal representative." Please read this agreement with the understanding that "I" means the pediatric patient.

CONSENT FOR TREATMENT

I consent to and authorize the attending physician, referring providers, and others of the healthcare team, including residents or providers in training, and students in other disciplines (the "Providers"), to perform healthcare services (including but not limited to healthcare examinations, treatment, diagnostic testing, transfers, and transportation) as deemed medically necessary in their professional judgment either in person or via telehealth. I understand I have the option to refuse the delivery of healthcare services (including telehealth) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits. Routine treatments may include, but are not limited to, placement of IV catheters, oral or nasogastric feeding tubes, urinary catheters, non-invasive testing, and lab draws.

If I am pregnant this consent also applies to my fetus/baby born during my admission.

CRITICAL CARE OR EMERGENCY PROCEDURES

In critical care areas, or in emergency situations, there are invasive procedures that may need to be performed to assist in the monitoring, supporting, and treatment of patients. These procedures may be used to support breathing and lung function, obtain vascular access, assist with diagnosis, and support nutrition. Examples of such procedures include but are not limited to intubation, gastric tube insertion, arterial line insertion, central venous catheter placement, chest tube insertion, and lumbar punctures. If these procedures, or any others, are needed I will be informed of the specific details of the procedures, any alternatives as well as risks and benefits in order for me to give informed consent. In the event of an emergency, the providers may need to proceed with necessary procedures prior to notifying the legally authorized representative.

CONSENT FOR TELEHEALTH SERVICES

I consent to telehealth care performed by the Providers. Telehealth involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively, "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth encounter and I have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
- If an emergency occurs during a telehealth encounter at a hospital or clinic, health care personnel at my location will manage the emergency. If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.
- I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law. All releases of information are subject to the same laws and regulations as in-person care.

Place Patient Identification Label Here

It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills associated with the provision of telehealth services.

CONSENT FOR MEDICAL PHOTOGRAPHS, RECORDING OR FILMING

I understand that CHCO is a teaching hospital, and I grant permission to take photographs, recordings, or video for treatment, payment, or internal operations as requested or required by my care providers. Recording or filming will not be released to the general media or for publication without my express written authorization.

CONSENT TO BE CONTACTED (Telephone Consumer Protection Act (TCPA))

By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for CHCO or their service providers to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, CHCO, their agents, representatives, or other service providers may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

RELEASE OF PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

I understand that any Protected Health Information (PHI) gathered or procedures undergone for research purposes will be covered under separate consent forms.

RELEASE OF INFORMATION (ROI)

CHCO may use or disclose my health information for treatment, payment, or internal operations. I understand that I may have access to all medical information resulting from the healthcare services provided. CHCO may share my health information with the healthcare team involved with my care at CHCO or elsewhere for continuity of care. CHCO is required to report certain unique medical conditions/lab results to outside agencies.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS (AOB)

- I agree to be responsible for any co-payments, deductibles, or other charges of CHCO and of providers rendering services not covered or paid by insurance or other third party payors – except as prohibited by any agreement between my insurance company and CHCO or by state or federal law.
- I authorize CHCO to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for provider services to the provider or organization furnishing the services.
- I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, delinquent charges and interest in the event CHCO has to take action to collect same because of my failure to pay in full all incurred charges within 60 days after receipt of the bill.
- The term of this AOB will be until final payments are made for any and all services.
- If and when there are changes to my/our insurance plans, I will notify CHCO staff and sign a new Admission Agreement form.
- I understand that not all providers are employees of CHCO, and I may be billed separately for their services. It is my responsibility to know what providers are covered under my insurance plan.

OTHER NOTICES

- Healthcare services at CHCO 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 Statues, limits the amount of damages recoverable from public employees and entities, requires a formal notice of claim, and places 180-day time limit on the period for filing such a notice of claim.
- For outpatient ambulatory clinic specialty or primary care services, this Admission Agreement is valid for one year from the date of signature. For all other services, a new Admission Agreement is required for each admission or delivery of care (e.g., inpatient admission or emergency department/urgent care visit).

My signature below also acknowledges that I have received the "Patients'/Parents' Rights and Responsibilities" either today or in the last year and I received CHCO's "Notice of Privacy Practices" during my first visit to CHCO.

Place Patient Identification Label Here

Print patient's name	Signature of Patient or Legally Authorized Representative
Date / Time	Print your name
Interpreter (as needed)	Relationship to patient
Guarantor Address	City/State/Zip

I DO NOT consent to being contacted by SMS (short message service) text message and automatically dialed appointment reminders, as applicable. (Initial here) _____

I DO NOT consent to participation in telehealth services. (Initial here) _____

To opt out of Patient Satisfaction Surveys, please notify front desk staff.

CHCO telephone consent requires a witness to the consent conversation:

1) _____ 2) _____
Name of staff obtaining telephone consent/Title/Date Name of witness/Title/Date

Place Patient Identification Label Here