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**HAND SURGERY OF COLORADO, LLC**

**CONSENT FOR ADMISSION, TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION**

I, as patient (or as agent or personal representative of the patient), authorize the admission to Hand Surgery of Colorado for out-patient care and treatment. I authorize and consent to the administration of all routine and emergency treatment, procedures and medications which the physician(s) responsible for diagnosis and treatment feel are necessary or desirable. The Hand Surgery of Colorado maintains personnel and facilities to assist my physician and surgeon in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY OR EVEN DEATH, from both known or unknown causes. I understand that except in emergency or extraordinary circumstances, consent will be obtained from or on my behalf before performance or administration of substantial procedures and that my physician will discuss such procedures with me or the person consenting on my behalf prior to obtaining such consent. I understand the physicians listed above are part owners of Hand Surgery of Colorado.

I authorize Hand Surgery of Colorado to release information and copies of medical records concerning my diagnosis and treatment to third-party payors and their agents and legal representatives, and to other third parties who may be obligated for payment of the hospitalization expenses incurred by me. For the purpose of the authorization which I have granted, I hereby waive any right to confidentiality of my medical records which I may have, and I hereby release Hand Surgery of Colorado from any claims or liability for release of medical records and information pursuant to the authorization I have granted.

I also authorize and consent to those routine tests deemed necessary by Hand Surgery of Colorado to ensure proper diagnosis for those health care professionals who may accidentally incur a potential infectious exposure from me in the course of my care. These tests may include HIV, Hepatitis or other infectious diseases that spread through bodily fluid contact.

**Statement of Financial Liability:** I understand that I am responsible for the full payment of the bill and the fact that I have assigned insurance benefits does not relieve my obligation to pay the bill in total. Unless other payment arrangements have been made in writing, any outstanding balance will be due within 30 days. I understand that Hand Surgery of Colorado is not responsible for items lost or stolen. I agree to pay Hand Surgery of Colorado all charges incurred for this date of service.

**Assignment of Insurance Benefits and Authorization to Release Information:** I hereby transfer and assign to Hand Surgery of Colorado all right and title and interest in any payment due for services described herein as provided in the above mentioned policy or policies of insurance.

**Medicare Patient's Certification Authorization to Release Information and Payment Request:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**Advanced Directives:** Each patient admitted to Hand Surgery of Colorado, LLC, will have access to Advanced Directives in accordance with Colorado state law.

- Yes     No    Do you have a Living Will?
- Yes     No    Did you bring a copy?
- Yes     No    Do you have a Legal Guardian/Durable Medical Power of Attorney?

**THE ABOVE HAS BEEN READ AND UNDERSTOOD AS INDICATED BY MY SIGNATURE BELOW.**

PATIENT'S OR AGENT'S SIGNATURE \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Witness \_\_\_\_\_

**HAND SURGERY OF COLORADO, LLC**  
2535 S. Downing Street, Suite 550  
Denver, Colorado 80210

**Patient Rights**

Patients have the right to be informed of their evaluation, diagnosis, treatment, alternative treatments, choosing among the alternative treatments if desired.

Patients have the right to receive an explanation of their treatment, participate and/or refuse treatment to the extent permitted by law, and be informed of the medical consequences of their actions.

Patients have the right to every consideration of privacy concerning their medical care.

Patients can expect their health records to be treated as confidential, refusing their release, and have the right to examine and receive an explanation of their bill.

The medical staff and employees of Hand Surgery of Colorado seek to treat their patients with respect, consideration and dignity, recognizing their individual needs and wishes, whenever possible.

To file a report, please ask for:

Director, Hand Surgery of Colorado  
2535 S. Downing Street, Suite 550  
Denver, Colorado 80210  
720.570.3304

Colorado Department of Health Care and Financing - Metro Denver, 303-866-3513

Medicare Ombudsman - [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

**Patient Responsibilities**

A patient has the responsibility to cooperate in his/her treatment program and is responsible for their actions if they refuse treatment or do not follow the doctor's recommendations.

A patient has the responsibility to provide information necessary for claim processing and promptly pay for services rendered consistent with his/her current health insurance, accepting personal financial responsibility for any charges not covered by his/her insurance.

A patient will be considerate of health care providers and patients in the center, directing family members or friends to act in a similar manner.

A patient has the responsibility to cooperate with his/her Physician and Center staff by following the directions, by asking questions if something is unclear, and by informing someone if they choose to refuse treatment.

A patient will provide complete and accurate information to the best of his/her ability about his/her health, any medication, and any allergies.

A patient has the responsibility to follow the treatment plan prescribed by his/her physician. A patient has the responsibility to inform his/her physician about any living will, medical power of attorney, or other directive that could affect his/her care.