Colorado Canyons HOSPITAL & MEDICAL CENTER

PATIENT DATA

CONSENT FOR TREATMENT AND ADMISSION AGREEMENT

O-127 1019

1. CONSENT FOR TREATMENT: I voluntarily request and consent to the medical healthcare services and procedures which may be performed upon me by Family Health West's employees, physicians, or others holding clinical privileges during this hospitalization or outpatient episode of care. This includes laboratory procedures, x-ray examination, medications, injections, and other services rendered to me under the instructions of my physician or his or her designees. I understand that I have the right to discuss proposed procedures or treatments with my physician, and to consent to, or refuse, such procedures or treatments. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment involves risk of injury or even death. I acknowledge that no guarantees have been made to me as to the result of treatment or services provided to me in this healthcare facility.

I further understand that it is my physician who has the medical knowledge and information on my condition, and who is or will be recommending proposed treatment after informing me of such, together with any risks or alternative treatments, and that it is the responsibility of my physician to obtain my informed consent to any proposed operation or procedure.

I understand that in the event that an employee of Family Health West is accidentally exposed to my blood/body fluids, or my physician deems it medically necessary, I consent to having my blood tested for Hepatitis and/or the HIV virus.

2. INDEPENDENT PRACTITIONERS - I understand that my physician and other physicians including radiologists, pathologists, and anesthesiologists may not be under the direction of Family Health West. I further understand that they may bill separately for their services and they may not accept the same insurance coverage as is accepted for services provided to me by this facility.

3. FINANCIAL AGREEMENT - In consideration for services rendered, I (or my Guarantor) assume financial responsibility and agree to pay Family Health West and my physicians for said services. I understand that financial counseling will be made available to me upon request. I understand I will receive monthly statements as long as my account has a balance due. In the event my account must be turned over to an outside agency for the purposes of collection, I understand and agree to pay all costs related to the collection process.

4. INSURANCE BENEFITS - I authorize payment to be made directly to Family Health West and my physicians, not to exceed the amount of their regular charges, from my insurance/healthcare benefits, otherwise payable to me for the healthcare services provided. I understand there is no guarantee of payment by my insurance company and that I am financially responsible for all charges not paid within forty-five (45) days of submission.

5. MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS - I certify that the information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Family Health West by the Medicare or Medicaid program. I understand that I am responsible for any deductibles, co-payments, and co-insurance amounts related to services provided.

6. PREAUTHORIZATION REQUIREMENTS - I understand that it is my responsibility to comply with all preauthorization requirements mandated by my insurance plan in relation to healthcare services provided by Family Health West and my physicians.

7. RELEASE OF INFORMATION - I authorize Family Health West and my physicians to release information from my medical records for purposes of treatment, payment, and healthcare operations as described in the Family Health West Notice of Privacy Practices.

8. PERMISSION TO BE CONTACTED BY CELL PHONE AND OTHER METHODS - I consent to be contacted by mail, text, email or by telephone (including my cell phone) regarding any matter related to my financial obligations to Family Health West or its assigns, affiliates, and debt collectors (Calling Parties). This includes contact that employs auto-dialer or unattended dialer technology and/or prerecorded messages. This also includes contact via any electronic mail addresses through individual or automatically generated electronic mail, and via text messaging through individual or automatically generated texts at (a) any cellular telephone number or land-line number or electronic mail

address that I or any person acting on my behalf may provide the Calling Parties at the time of registration or (b) at any telephone number the Calling Parties can find me through their search methods such as skip-tracing or internet searches.

If I elect to revoke consent to call my cell phone, I agree to call the FHW Compliance Officer at (970) 858-2739.

9. NON-SMOKING POLICY - I understand that all Family Health West facilities (owned/leased) are smoke-free and I understand smoking is prohibited in all campus buildings and parking areas.

10. PERSONAL VALUABLES - I understand that Family Health West has a safe and that I, upon my request, may store money and valuables in the safe. I understand that Family Health West is not responsible for the loss or damage of cell phones, glasses, dentures, or other valuables unless they are placed in the safe.

11. FIREARMS - I understand that Family Health West reserves the right to refuse to provide services to me if I bring a firearm into the facility.

12. LEAVING AGAINST MEDICAL ADVICE - If I choose to leave a Family Health West facility against or without the advice of my physician, I hereby release the physician and Family Health West, and its agent and employees, from all liability for any ill effects that may result.

13. NONDISCRIMINATION POLICY/PATIENT RIGHTS - Family Health West does not discriminate against any person on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law. Family Health West provides a copy of the Patient Rights and Responsibilities to inpatients and swing bed patients and signature on this form serves as acknowledgement of receipt.

14. HIPAA PRIVACY (Inpatients and Outpatients)

__Yes __ No I give Family Health West permission to disclose my health information to those persons directly involved in my care or payment for healthcare services (e.g., family members, relatives and/or close friends)

__Yes __No I have been offered a copy of Family Health West's Notice of Privacy Practices

HIPPA PRIVACY (Inpatients)

__Yes __No I give Family Health West permission to disclose my general medical condition to other persons who ask for me by name (e.g., general medical condition might be "he is in stable condition" or "her condition is declining")

__Yes __ No I give Family Health West permission to disclose my name, room number, and general medical condition to members of the clergy

__Yes __No I give Family Health West permission to notify family members or my personal representative of my location, general medical condition, or death

__Yes __No I give Family Health West permission to place my name and room number on the facility directory

This form has been fully explained to me and I certify that
I have had the opportunity to ask questions and I understand its contents.

Signature of Patient (or Authorized Representative)	Authorized Representative Relationship to Patient
Signature of Witness	Date

Reason patient is unable to sign

Colorado Canyons HOSPITAL & MEDICAL CENTER
Adult Rehabilitation

300 W. Ottley Avenue
Fruita CO 81521
Phone: (970) 858-2147
Fax: (970) 858-4569

MEDICAL SCREENING FORM

H-312 0420

Patient's Name: _____ Date of Birth: _____ Age: _____
Birth Gender ❒ Male ❒ Female Preferred Gender:_____ Preferred Pronouns:_____
Physician's Name:_____
Are you currently: ❒ Working ❒ Not working ❒ Retired Occupation:_____
Please list any communication barriers (i.e. hearing, vision, speech, language): _____
_____
Do you live independently or require assistance (why)? _____
Type of housing: ❒ House ❒ Apartment ❒ Condo Other: _____
Do you have stairs? ❒ YES ❒ NO
Emergency Contact:_____ Relationship:_____ Contact Phone: _____

PAST MEDICAL HISTORY

Do you exercise regularly? ❒ YES ❒ NO How often/What type of exercise? _____
Do you use tobacco? ❒ YES ❒ NO Do you drink alcohol? ❒ YES ❒ NO
Is there a chance you could be pregnant? ❒ YES ❒ NO Do you use marijuana? ❒ YES ❒ NO
Allergies: _____
Please list past surgeries and dates: _____
_____
_____

Please check all current diagnoses:

❒ Type I/II Diabetes	❒ Multiple Sclerosis	❒ Hypertension	❒ Concussions
❒ Osteoarthritis	❒ Thyroid Dysfunction	❒ Seizures	❒ Rheumatism
❒ HIV / Hepatitis	❒ Cancer	❒ Anxiety	❒ Chron's Disease
❒ Asthma	❒ Alzheimer's Disease	❒ Migraines	❒ COPD
❒ Dementia	❒ Dizziness	❒ Heart Disease	❒ Osteoporosis
❒ Depression	❒ Shingles	❒ Liver Disease	❒ Parkinson's
❒ Stroke	❒ Incontinence	❒ Lupus	❒ Pacemaker
❒ Kidney Disease	❒ Vascular Disease	❒ Clotting Disorder	

Please list any other medical conditions that will be helpful to guide your care: _____
_____

Are you currently experiencing any of the following?

❒ Unexplained weight loss	❒ Difficulty swallowing	❒ Dizziness
❒ Changes in bowel or bladder	❒ Headache	❒ Vision changes
❒ Fever / night sweats	❒ Nausea / vomiting	❒ Shortness of breath
❒ Changes in appetite	❒ Numbness or tingling	❒ Poor balance / falls
❒ Tinnitus / ringing ears	❒ Angina / chest pain	❒ Abdominal pain
❒ Bloody stool	❒ Pain with urination	❒ Vertigo

Current Medications: _____
_____

CURRENT SYMPTOMS

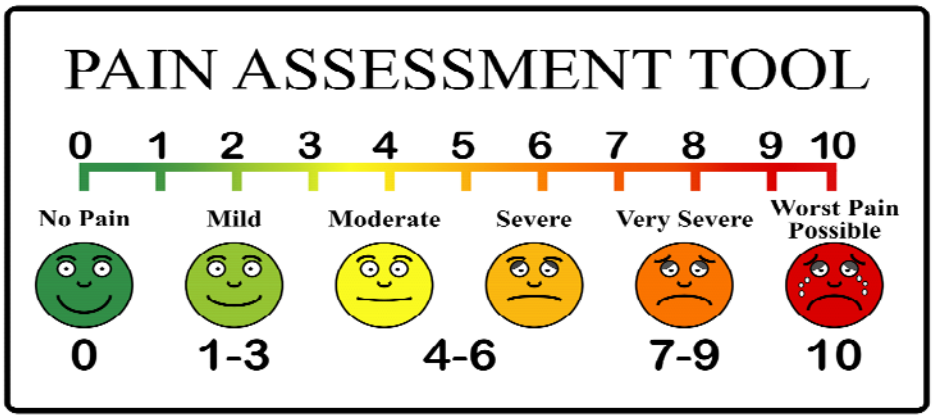
Current reason for being seen? _____
When did these symptoms start? _____
How did this injury occur? _____
My symptoms are currently: ❒ Getting better ❒ Getting worse
What makes your symptoms worse? _____ Better? _____
Any imaging taken? (X-ray, MRI, CT, etc.) Imaging results? _____
Please list any previous treatment for this injury: _____
_____

Patient Specific Functional Scale:
List any activities you are having difficulty with and rate them from (Unable) '0' - '10' (no difficulty)

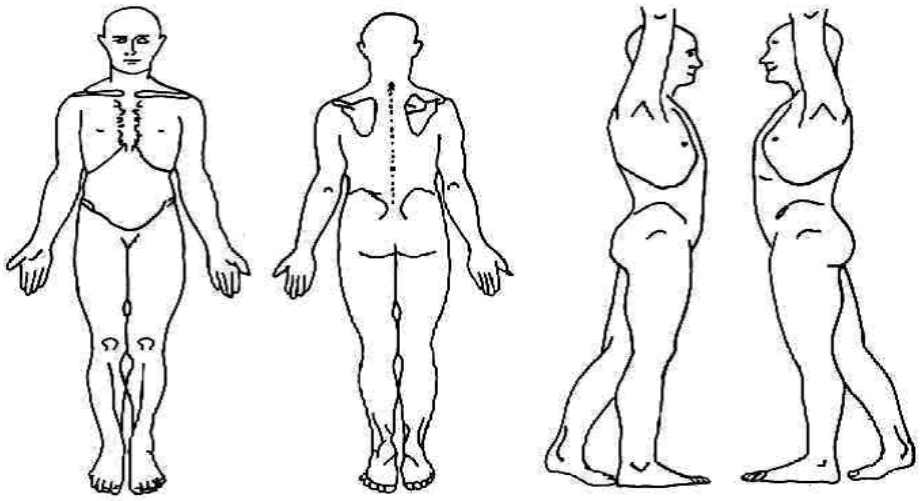
1._____difficulty? 0-1-2-3-4-5-6-7-8-9-10
2._____difficulty? 0-1-2-3-4-5-6-7-8-9-10

My pain is: (**mark** all that apply) ❒ Constant ❒ Sharp ❒ Dull ❒ Ache ❒ Throbbing ❒ Tingling ❒ Numbness ❒ Burning

Circle the appropriate number that applies to your current pain level:



Mark the area of your symptoms:



What are your goals for treatment? _____
_____