DivineHealth Group

Consent for Treatment and Acknowledgment of Information Received

CLIENT RIGHTS and RESPONSIBILITIES:

I have been given a handout on Client Rights and Responsibilities, including information about how to file a complaint or appeal. I may make a complaint without jeopardizing my care. I have read the Client Rights and Responsibilities handout and know that I may ask questions. I understand my rights and responsibilities and that I may also ask the staff for more information.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES:

I have been offered a copy of the current Notice of Privacy Practices. The Notice gives information about how Divine Health Group may use or disclose my Personal Health Information and about my rights in regards to this information.

ACKNOWLEDGMENT OF EMERGENCY SERVICES INFORMATION:

I have received written information on how to contact emergency services.

FINANCIAL DISCLAIMER:

I have been offered a copy of Divine Health Group fee information. I have read the handout and had an opportunity to ask questions. I understand I am financially responsible for full payment of charges for services provided to me and that payment is expected at the time of service. The information given by me in applying for payment is correct to the best of my knowledge. I request that payment of authorized benefits be made on my behalf to Divine Health Group. I may speak to staff regarding special payment arrangements.

LIMITS OF CONFIDENTIALITY:

I have been given a handout that explains the Limits of Confidentiality. I have read the handout and had an opportunity to ask questions. I understand the Limits of Confidentiality**.**

HEALTH INFORMATION EXCHANGE:

I understand that Divine Health Group participates in the Health Information Exchange, which is a method to electronically share personal health and medical information securely between doctors, hospitals and other healthcare providers when it is needed for patient care. I understand that my labs may be delivered electronically through the Health Information Exchange if I have labs ordered through Divine Health Group. I understand that I may opt-out of the Health Information Exchange program if I do not want other physicians and other participating healthcare providers to access my electronic health information.

MANDATORY DISCLOSURE:

I understand I have a right to know the name, education, license and /or credentials of the clinical staff of Divine Health Group. I have been given a handout of this information. I have had a chance to read this information and to ask questions. I understand this information.

ADVANCE DIRECTIVES:

I have been offered information on Advance Directives. I understand my rights about Advance Directives, including my right to get care with or without an Advance Directive. For more information on Advanced Directives, I may visit the website of the Colorado Bar Association, http://www.cobar.org. Information may also be found on the Colorado Health Networks website, http://www.yourchn.com.

PCP CARE COORDINATION

I consent to Divine Health Group coordinating care with my or my minor child's primary care physician regarding medications and diagnosis.

PHARMACY CARE COORDINATION

I consent to Divine Health Group coordinating care with my or my minor child's Pharmacy of choice regarding medications and insurance as appropriate.

OFF-SITE TELEMEDICINE/TELETHERAPY SERVICES:

I am interested in receiving services via telemedicine/teletherapy. I have been informed of my diagnosis and proposed telemedicine/teletherapy treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way. I understand that my privacy and confidentiality will be protected. Divine Health Group maintains the confidentiality of Protected Health Information (PHI) in accordance with all applicable state and federal requirements. Please check the appropriate box below:

*I agree to participate in and receiving services via telemedicine/teletherapy.

*I agree to participate in and receiving services via telemedicine/teletherapy off-site.

*I agree to have medical students present during my appointment via telemedicine/teletherapy.

CONSENT TO TREAT:

I have been given sufficient information about the above items to make an informed choice to seek health services and treatment with Divine Health Group. I understand services have a better chance for success if I attend sessions, participate and cooperate with recommendations. I understand that I may be given the choice to participate in tele-health. I understand I am free to seek services from Divine Health Group at any time. I give my consent for services for myself or my minor child.

NO SHOW AND LATE POLICY:

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide a minimum of 24 hours' notice. You may do so by calling our office phone at 719-413-5261, emailing divinehealthgroup@outlook.com, or using the patient portal.

If you do not show up for your appointment, or cancel, or reschedule within 24 hours of your appointment time,

we will consider that a no-show. No show appointments may be subject to a $25 fee. No show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no show fee might prevent you from receiving necessary care, please contact us.

Individuals who present 10 minutes or later to their appointment may be treated as a no show and asked to reschedule their appointment as not to disrupt the schedule of other patient appointments.

Dismissal of care may be implemented for repeat no shows, late attendance, and cancellations at the discretion of the office manager.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice managements sole discretion. If you have any questions about our cancellation or late policy, please call 719-413-5261 to discuss this with the practice manager.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you gave written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases the most those providers may bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

*Cover emergency services without requiring you to get approval for services in advance (prior authorization)

*Cover emergency services by out-of-network providers

*Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits

*Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit

If you believe you've been wrongly billed, you may contact: 719-413-5261. Visit the CMS No Surprises Act Consumer Website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Patient Signature or Guardian/Authorized Representative's Signature

Print Guardian/Authorized Representative's

Date of Signature