DELINQUENT ACCOUNTS: I understand that if Denver Health is slow in trying to collect my bill or gives me extra time to pay, that does not forgive my need to pay. If my bill is overdue, Denver Health may refuse to provide care until my bill is paid, unless not allowed by law such as an emergency. Interest on unpaid bills may be charged at the highest rate allowed by law. If Denver Health has to sue me to collect my bill, Denver Health may file such lawsuit in the District or County Courts of Denver, Colorado. I agree that Denver Health can provide my medical and billing records in any such collection lawsuit and related matters. In the event that DHHA wins in court, I agree to pay to Denver Health its reasonable lawyer’s fees, court costs, and expenses of collection. I allow Denver Health to obtain copies of my credit bureau reports and to obtain from anybody any information about me that is reasonably necessary for collection purposes. I consent to be contacted by regular mail, email, text, or telephone (including wireless/cell number) regarding any matter to my account(s). This consent applies to all Denver Health providers and/or any company working for Denver Health. This consent includes any updated or additional contact information that I may provide, and includes phone calls that employ auto-dialer technology and prerecorded messages. If I want to cancel this consent, I agree to provide notice of that by contacting Denver Health Patient Financial Services.

BEHAVIOR EXPECTATIONS: I understand that if I am physically or verbally threatening, hostile, or violent while at Denver Health, I may be refused any further care unless it is an emergency. I understand that Denver Health Security and the Police will be called and that I might be prosecuted. I also understand that while admitted for treatment to the hospital as an inpatient at Denver Health, I may not leave my hospital room to go outside.

NON-SMOKING POLICY: I understand that I am not allowed to smoke, use any tobacco products including e-cigarettes or vaping on or next to Denver Health and any of its locations. I cannot leave Denver Health to smoke during my inpatient hospital admission.

CONTRABAND AND PERSONAL PROPERTY: I understand that I may not keep any weapons, explosives, drugs, marijuana, alcohol or other items not allowed by law or hospital policy (contraband) while I am at Denver Health. Should Denver Health suspect I have any contraband, Denver Health has my permission and may search my clothing, personal belongings and area of care. If any contraband is found, Denver Health may take possession of the items and dispose of them in any manner allowed by law. Denver Health may also notify Law Enforcement. I understand that I should not have any money or other valuable property while at Denver Health. Denver Health is not responsible for damage to, theft, or loss of my money and other property.

GOVERNMENTAL IMMUNITY: Medical care or treatment at Denver Health may be given by people who are considered public employees by the Colorado Governmental Immunity Act (Article 10 of Title 24 of the Colorado Revised Statutes). That law limits the amount of money I can receive if I make a claim in the District or County Courts of Denver Health or its employees. I understand that the Colorado Governmental Immunity Act requires that I, or my lawyer, file a formal notice of claim against Denver Health. That notice must be filed within 182 days of finding out I have an injury or as stated by the Governmental Immunity Act.

DURATION OF CONSENT: I understand that this Consent will be active for as long as I receive healthcare at Denver Health, or until I cancel this Consent in writing. If I cancel this Consent, it will be cancelled only as to future care and not as to care I already received. If I have already received care but could not sign this Consent until now, I agree that this Consent will apply to the care that I have already received. I may be asked to sign additional Consent forms on a yearly basis, upon each admission to the hospital or as required by hospital policy.

AUTHORIZED REPRESENTATIVE/GUARANTOR: If I am not the patient and I sign this Consent as the patient’s Authorized Representative, I understand that both the patient and I will be fully bound by this Consent. I understand that, by signing this Consent I GUARANTEE AND AGREE TO MAKE PAYMENT OF ALL OF THE PATIENT’S HEALTHCARE EXPENSES, and that if payment is not made, the patient and I will be subject to the remedies provided in the paragraph entitled, Delinquent Accounts, above.

ACKNOWLEDGMENT: I acknowledge that I have read this Consent and understand and agree with what it says. Any questions that I had about this Consent have been answered. No one has forced me to sign this Consent against my will. I have either received or have been offered a copy of this Consent.

I CERTIFY THAT THE INFORMATION I PROVIDE BELOW WILL BE TRUE AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE INFORMATION TO OBTAIN HOSPITAL OR MEDICAL CARE IS A CLASS 1 MISDEMEANOR PUNISHABLE UPON CONVICTION BY UP TO EIGHTEEN (18) MONTHS IMPRISONMENT OR A $5,000.00 FINE OR BOTH (C.R.S., §§18-13-124 and 18-1.3-501). I UNDERSTAND THAT IF I PROVIDE FALSE, MISLEADING, OR INCOMPLETE INFORMATION AS TO MY IDENTITY OR RESIDENCE ADDRESS OR WHEN APPLYING FOR A FINANCIAL AID PROGRAM, DENVER HEALTH MAY REPORT ME TO LAW ENFORCEMENT AND MAY REFUSE TO PROVIDE ME WITH NON-EMERGENCY-RELATED HEALTHCARE.

For care that I am receiving today as an outpatient if it applies, I acknowledge that I am being seen in a Denver Health urgent care clinic ______ or emergency department ______. (Please initial one) Emergency services are for more severe conditions and often result in higher out of pocket costs for the patient.

If you are signing this Consent as the patient’s Authorized Representative, put an “X” in the box that shows your legal relationship to the patient:
- [ ] patient’s parent
- [ ] patient’s legal custodian
- [ ] patient’s conservator
- [ ] patient’s legal guardian
- [ ] patient’s foster parent
- [ ] patient’s spouse
- [ ] patient’s child over the age of 18
- [ ] other legal relationship: ________________________________

Print full legal name of Patient:

Authorized Representative Signature/ Date (mm/dd/yy) Time (00:00)

Print full legal name of Authorized Representative:

DHHA Witness Signature/ Date (mm/dd/yy) Time (00:00)

PRINT name of DHHA witness:

OFFICE USE ONLY: Patient is a minor. Consent was obtained by telephone from ________________________, who is the patient’s: ________________________.

Patient is unable to provide consent due to condition. Patient is unable to sign due to condition; however, did provide Oral consent.

Patient refused to sign.

DHHA Staff Person’s Name (Printed)