PRECISION
SPINE CENTER

PATIENT BILL OF RIGHTS

Patient Rights:
Precision Spine Center supports the rights of all patients across the lifespan including geriatric and adult populations. These rights may be exercised through the patient individually or through their authorized surrogate decision maker.
You **have the right to. . .**

1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
2. Receive care, treatment and visitation regardless of disability, national origin, culture, age, color, race, religion, sex, gender identity, sexual orientation. No one is denied exam-ination or treatment of an emergency medical condition because of their source of payment.
3. Give informed consent for all treatment, procedures, and/or production of recordings, films or other images when used for other than identification, diagnosis or treatment.
4. Be informed of your health status/prognosis, including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events.
5. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
6. Receive appropriate assessment and prompt management of your pain.
7. Be treated with respect and dignity.
8. Experience personal privacy, comfort and security to the extent possible during your visit/ stay
9. Experience confidentiality of all communication and clinical records related to your care. You will receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
10. Be communicated with in a manner you can understand which is tailored your age, lan-guage, understanding and ability including access to interpreter services and communi-cation aides, at no cost.
11. Receive care in a safe setting.
12. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
13. Have access to protective services (e.g., guardianship, advocacy services, and child/ adult protective services).
14. Request medically necessary and appropriate care and treatment.
15. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
16. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
17. Receive information about Advance Direc-tives. Set up or provide Advance Directives and have them followed.
    Designate an authorized surrogate deci-sion-maker as permitted by law and as need-ed.
18. Participate in decision-making regarding ethi-cal issues, personal values or beliefs.
19. Know the names, professional status and experience of your caregivers.
20. Have access to your medical records within a reasonable timeframe.
21. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
22. Be informed of the facilities complaint and grievance procedure and whom to contact to file a concern, complaint or grievance. Note: If you have financial issues or questions, please contact Precision Spine Center Operations at (303)790-2225. Our priority is for you to have a positive patient experience. If your concerns are not being resolved with your immediate care giver or the department manager or administrative staff, please call the us at the number listed above.

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You also have the right to file a complaint with the appro-priate oversight boards including the Colorado Board of Medical Examiners, the Colorado Dental and Podiatry Boards and the Colorado Department of Regulatory Agencies. Contact information will be provided by the facility patient advocate upon request.

Patient Responsibilities:
You have the responsibility to . . .

1. Ask questions and promptly voice concerns.
2. Give full and accurate information as it relates to your health, including prescription and non-pre-scription medications.
3. Report changes in your condition or symptoms, in-cluding pain, and request assistance of a member of the health care team.
4. Educate yourself. Learn about the medical tests that are being performed and understand your treatment plan.
5. Follow your recommended treatment plan.
6. Be considerate of other patients and staff.
7. Secure your valuables.
8. Follow facility rules and regulations.
9. Respect property that belongs to the facility or others
10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

Signature: _____
Date: _____ Time: _____

Patient Barcode Label
Must be placed in this space

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Patient Label

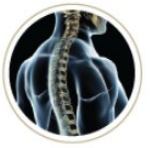
Consent for Medical Treatment

1. CONSENT FOR HEALTH CARE SERVICES. I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Precision Spine practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Precision Spine practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice. I further acknowledge Precison Spine and providers do not provide medical aid in dying medication or related services. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document. I understand that failure to comply with scheduled appointment times will put me at risk for discontinuation of medical care.

2. NON-PRECISION SPINE PRACTITIONERS. I understand that I may receive services from professionals who provide care to me who are not employees or agents of a Precision Spine Center practice. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from the Precision Spine Center. I understand that, in some cases, these non-Precision Spine Center professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3. MEDICARE and/or MEDICAID CERTIFICATION. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4. FINANCIAL AGREEMENT. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payor source. I understand the practice has pre-determined the charges for certain procedures, supplies, and treatments that these charges are listed in the Precision Spine Center fee schedule and that these prices are incorporated by reference into this Contract. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I agree to pay these current pre-determined rates for each supply and service I receive as part of my treatment. I acknowledge this Contract means I personally have full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. I acknowledge that estimated patient responsibility is due at the time of service and that any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 180 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt or any action on this Contract. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice.



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Patient Label

5. **COMMUNICATIONS CONSENT.** By providing my cell or other phone number(s), I expressly consent to Any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services. I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by the practice or any entity to which the practice assigns my account, including any collection agency. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account. I hereby acknowledge and agree that the practice has not made any implied representations about the charges I am personally obligated to pay.

6. **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

7. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

8. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Precision Spine Center's web-site. I understand this acknowledgment in no way affects the care I shall receive.

Acknowledge: (Initials)_____

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT