



Consent for Treatment

Request for Provision of Service: I understand that by signing this consent I hereby give permission to MSD and its agents to perform testing and treatment.

Records and Release of Information: Transmitted Data may become part of my medical record. Mountain Sleep Diagnostics may use or disclose my health information consistent with my signed release of information, or, without my consent for treatment, payment, or healthcare operations, or when required by law. All releases of information are subject to the same laws and regulations.

Video and Audio Taping: I hereby give my consent for videotaping, audio taping and/or photography for professional use in diagnosing and recommending treatment. I understand that my name will be kept confidential at all times, regardless of the use of these recordings.

Assignment of Benefits & Financial Responsibility: I assign and transfer to MSD any and all rights to receive any insurance benefits otherwise payable to me for provided products or services. I authorize my insurance company to furnish to any agent of Mountain Sleep Diagnostics any and all information pertaining to my insurance benefits and status of claims required by my insurance program. I acknowledge that I am responsible for my co-payment, unmet deductible amount or other amount not covered by my insurance program. I agree to pay all bills promptly and in accordance with MSD's rates and terms. At the time of the visit, I will pay any co-payment, co-insurance and/or deductible amounts that are due. I will also pay the balance due after payment by any insurer or third-party payer. I understand MSD may charge for late cancellation (within 48 hours) and/or missed appointments. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses.

MSD Privacy Practices: Privacy practices for Mountain Sleep Diagnostics can be located at www.mountainsleepdiagnostics.com under Legal Notices. We encourage you to read in totality.

Contact Consent: By providing us with your phone number(s), you give express authorization to be contacted at that number, as well as authorize such contact by our agents and assigns. We may also contact you by sending text messages or emails, using any address you provide. Methods of contact may include using prerecorded/artificial voice messages and/or the use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

Consent for Voicemail: I give my consent for MSD, associated providers and staff to leave specific information regarding my study, treatment or other services provided by MSD on my personal voicemail using the number MSD has on file.

Yes

No

Disclosure of Information: I give Mountain Sleep Diagnostics and their staff permission to share information regarding my medical care with the following individuals:

Health Information Exchange: By consenting to treatment provided by MSD you are also opted in to the Health Information Exchange. This service allows the facility to pull your medical records from other participating facilities in the exchange network as well as share medical records with the exchange network. This service greatly reduces the time necessary to gather medical records and provides a more comprehensive healthcare experience for you. If you would like to Opt Out of the Health Information Exchange, please reach out to us at (303) 392-5923 to obtain an Opt Out form for signature.

Patient Name (Printed): _____

Patient's Legal Representative Name (Printed): _____

Relationship to Patient: _____

Use if patient is a minor or you serve as their medical power of attorney

Signature: _____ **Date:** _____



Consent for Telehealth

Mountain Sleep Diagnostics offers appointments and limited services via telehealth. Telehealth involves remotely treating patients through telecommunications systems, including information, electronic, and communication technologies, while patient and provider are located at separate sites. Telehealth involves using a virtual platform to treat patients remotely using audio and video transmission, including the electronic transmission of my private health information (“PHI”)(collectively, “Transmitted Data”). Though MSD takes steps to ensure Transmitted Data is sent via secure electronic means, I understand that there is a possibility that Transmitted Data could be intercepted and become available to a third-party. I understand that all confidentiality protections required by law or regulation will apply to my care. I understand that due to the nature of medical practice, not all medical services may be available via telehealth, and it is within the sole discretion of my provider to determine whether telehealth is appropriate for my care and treatment. I understand that I have the right to refuse or stop participation in telehealth services at any time.

Emergency Cases: In the event you are conducting your telehealth visit and experience a medical emergency, please immediately call 911 and as much as possible, stay connected with your telehealth provider until help arrives.

Fees: You/your insurance will be billed for your telehealth visit and you will be responsible for any fees that are assigned patient responsibility. Please note that we will not continue a telehealth visit if you are operating a car or are in a situation that we determine could be dangerous. If we have to disconnect for these reasons, this may result in a fee for the provider’s time spent preparing for the visit and attempting to conduct said visit.

By signing this form, I hereby declare that I agree and understand the information above.

Signature: _____ **Date:** _____



Authorization to Release Patient Health Information | Personal Medical Records Release

This authorization is necessary for us to comply with state and federal laws pertaining to the request and or release of medical records regarding the patient identified below. Please provide all of the requested information. Failure to provide all requested information may prevent Mountain Sleep Diagnostics from acting on this authorization.

Patient Name:

Date of Birth:

Person/Entity Authorized to Release:

Name:	Mountain Sleep Diagnostics
Phone/Fax:	(303) 396-5923 (303) 957-5414

Request Medical Records Sent To: Please list yourself or your minor as you are authorizing us to share your records with you.

***Please note: If you require us to send your records elsewhere in the future, you will request a new record release form to complete*

Name:	
Address:	
Phone/Fax:	

Records Requested:

All Medical Records

Records for a certain date range: _____ to _____

Billing Records Only

Other (please specify): _____

Sensitive Data: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

I Authorize Release

I Do Not Authorize Release

This is not applicable to me

I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.

Date: _____ **Signature:** _____

Please note, this request will expire 365 days from signature date. A copy of your Drivers' License is required to execute the requests of this document.