Health Care Partners Foundation, Inc.
Correctional & Community Based Health Care Systems
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(888) 201-1499

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Health Care
Partners Foundation, Inc (HCPF) and MedXTrust

CONSENT TO SERVICE

This agreement applies to Health Care Partners Foundation, Inc. (HCPF), and MedXtrust and all health care providers (Providers) providing care. On behalf of myself, my minor child, or if I am the healthcare decision maker for the patient named below, then for the patient named below, I acknowledge and consent to the statements made in this form. Changes to this form are not binding on HCPF and MedXTrust, or any of its affiliated providers. This form (the "Agreement") applies for care and treatment now and moving forward, until I sign another version of this Agreement or revoke this one.

- I consent to receive care from HCPF and MedXTrust, Providers, and their employees and contractors. I consent to services the Providers consider reasonable and necessary for care and treatment, including examinations, administration of medications including psychotropic medications when applicable, and other health and behavioral/mental health care services. I understand that I have the right to agree to or refuse care in accordance with the law.
- I understand guarantees about health care cannot be made.
- I understand that care and treatment may be provided by physicians, physician assistants, nurse practitioners, therapists, counselors, and other health care providers.
- I hereby consent and grant to HCPF and MedXTrust the right an authority to take photographs, images, audio recordings, and/or video recordings (collectively "images or recordings") in connection with diagnosis and treatment. I agree that upon creation of such images or recordings are owned by HCPF and MedXTrust and may be used for quality improvement and education. I understand that I have the right to request that recording or filming stop at any time. I acknowledge that HCPF and MedXTrust may disclose these images as required or permitted by law.
- I understand that certain services may be provided using remote telehealth/tele counseling/teletherapy technology. Such services involve a provider who is not at the same location where I am when I am receiving the services, and often includes the transmission of audio, video, images and other data. I understand that this technology is not always available.
- I understand that my healthcare provider wishes to engage in a telemedicine/tele counseling/tele addiction consultation which is HIPAA compliant.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
- In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
- I consent to receive health care services, including telehealth, for the Health Care Partners Foundation (HCPF) jail to community transition program. I consent to health care services my health care providers consider reasonable and necessary including telehealth, tele counseling, telemedicine, telepsychiatry, tele-addiction, examination, diagnostic tests, laboratory services, rehab services, administration of medical and mental health medications, community resource well-being services, and other health care and/or community-based services. I understand that I have the right to agree to or refuse care.
- I understand guarantees about my health care and the above-mentioned services cannot be made.
- I understand that my medical/mental health care and treatment may be provided by physicians, nurse practitioners, physician assistants, nurses, medical staff, care coordinators, community resource staff and other health care providers.
- I understand and agree to telehealth photographs, images, audio recordings, and/or video recordings of me when I am a patient of HCPF. I understand HCPF may use these images and/or recordings for quality improvement, consultations and/or education.
- HCPF may disclose these images as required or permitted by law.
- I understand and agree that HCPF will provide all necessary medical services as determined by the HCPF Provider based on national standards of care and best practices. I also understand and agree that for further compliance in continuity of care involving pre-existing conditions and/or self-inflicted injuries, that any services determined for continued medical, dental, mental health, addiction, and/or based upon patient request, including off-site treatment and/or follow-up care, shall be the sole financial responsibility of the patient.

Regulatory requirements applicable to mental health professionals:

Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.
In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.
Client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.
The client may seek a second opinion from another therapist or may terminate therapy at any time.
Information provided by the client during therapy sessions is legally confidential. The limitations of confidentiality include clinician's inability to ensure confidentiality on both ends of a telecommunication conversation. The therapist will share patient personal information with legal or medical personnel only if patient is a threat to themselves or others, if there is suspicion of elder or child abuse; or if patient has provided written consent to release information.
Additionally, disclosure of confidential information is not necessary when: In an emergency, Pursuant to a court order or involuntary procedure, If the sole purpose of the professional relationship is for forensic evaluation, If the client is in the physical custody of either the department of corrections, The client is incapable of understanding such disclosure and has no guardian to whom disclosure can be made.
Patient consents to attending therapy via the internet. The provider offers online options that are HIPPA compliant. It is up to the patient to ensure that they are in a private location to freely discuss mental health. Patient agrees to attend therapy in the state of Colorado, where provider is licensed, and reschedule appointments as needed.
Mental health providers abide by the ethical standards which are outlined by the American Counseling Association, as well as those outlined by professional mental health organizations such as NBCC and APA.
Mental health providers of HCPF ensures clinical competence and adherence to ethical practices through group staffing and with other licensed mental health practitioners. Mental health providers are licensed as an independent practitioner in the state of Colorado.

Health Information Exchange

Health Care Partners Foundation, Inc and MedXTrust participates in the electronic exchange of protected health information ("PHI") with other health care providers and health insurance plans approved through approved heath information exchange organizations. Through HCPF and MedXTrust participation, PHI may be accessed by other providers and health insurance plans or other permitted recipients of PHI, as permitted by law, for treatment, payment and health care organization purposes. These health information exchanges maintain safeguards to protect the privacy of your PHI. You are able to opt-out of having your PHI accessed on these exchanges. Please contact HCPF for information on how to opt-out.

Consent to Telephone Calls, Text Messages, Voice Mail Messages, and Emails

By providing a telephone number, whether cellular or otherwise, to HCPF and MedXTrust now or at a later time, I consent to receiving telephone calls and/or text messages, or other communications using live, artificial, or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from HCPF, MedXTrust and its affiliates. Affiliates include our health care providers, business associates, agents, contractors, vendors, assigns, successors, servicers, and collection agencies. I certify, warrant and represent that I am authorized to receive calls at any of the telephone numbers provided. The text messages and phone calls may be related to any purpose, including related to my account and my health care, such as appointment reminders or offers for additional

services. I understand that standard text messaging rates may apply. I agree that HCPF, MedXTrust and my health care providers may share with affiliates any telephone number(s) I provide to HCPF and MedXTrust so that the affiliate(s) may make calls or texts on behalf of HCPF, MedXTrust or my health care provider. I understand that I may revoke my consent to receive such calls and texts at any time. The callers may leave the name of the company making the cal or reference whom the caller is representing. By providing an email address, I give HCPF, MedXTrust and its affiliate(s) permission to contact me by email about my or my dependents' health care or costs related to health care using any email address I provide to HCPF, MedXTrust or its affiliate(s). Affiliate(s) may use any email address or phone number I give HCPF and MedXtrust or that they may obtain for me.

YOUR INFORMATION, YOUR RIGHTS AND OUR RESPONSIBILITIES
NOTIFICATION OF PRIVACY PRACTICES
Health Care Partners Foundation and MedXTrust

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **You can get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of our request. We may charge a reasonable, cost-based fee. You have the right to receive your test reports from laboratories and to request that copies of your reports be sent to other persons or organizations that you want to receive them.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **You can request confidential communications.** You can ask us to contact you in a specific way (i.e. home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use or share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we have shared information.** You can ask for a list of the times we've shared our health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosure (such as any you asked us to make). We will provide one accounting a year but will charge a reasonable, cost-based fee if you ask for one.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy upon request.
- **Choose someone to act for you.** If you have given some medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action by attaching the power of attorney or proof of legal guardianship to your record.
- **File a complaint if you feel your rights are violated.** You can complain if you feel we have violated your rights by contacting us using the information on last page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choice about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:** share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

- **In these cases, we never share your information unless you give us written permission.** Marketing purposes, sale of your information, most sharing of psychotherapy notes.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **Treat you.** We can use your health information and share it with other professionals who are treating you. (Example: a doctor treating you for an injury asks another doctor about your overall health condition)
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. (Example: We use health information about you to manage your treatment and services)
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. (Example: We give information about you to your health insurance plan so it will pay for your services)
- **How else can we use or share your health information?**
  - We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health. (Examples of helping with public health and safety issues we share health information about are: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety)
  - Do research: we can use or share your information for health research
  - Comply with law: we will share your information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
  - Respond to organ and tissue donation requests: we can share health information about you with organ procurement organizations
  - Work with medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies
  - Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you for workers' compensation claims; for law enforcement purposes work with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services
  - Respond to lawsuits and legal actions: we can share health information about you in response to a court or administrative order, or in response to a subpoena
  - Confidentiality of Alcohol and Drug Abuse Records: We may not share information on any alcohol or drug use without your written permission or a court order except when it is needed by medical personnel in a medical emergency or needed for research, auditing or program evaluation.
  - HIV Test and AIDS related conditions: State law requires that we have your permission or a court order before we share the results of any HIV test or any diagnosis of AIDS or an AIDS-related condition.

COMPLAINTS AND CONTACT PERSON FOR ANY REQUESTS PERTAINING TO THIS AGREEMENT

– If you would like to submit a comment or complaint about our privacy practices or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Health Care Partners Foundation,
Inc 1411 HWY 50 W
No. 1040
Pueblo, CO. 81008

Release of Information

Coverage: This form covers all services or goods provided or to be provided to patient by any health care provider rendering care to the patient while the patient is receiving services or goods from Health Care Partners Foundation, Inc and MedXTrust.

Health Care Partners Foundation, Inc and MedXTrust (or its subsidiaries and affiliates) is not responsible for the healthcare that is provided to the patient by third party healthcare providers who do not work for Health Care Partners Foundation, Inc and MedXTrust. As used in this form, "Health Care Partners Foundation, Inc and MedXTrust" includes any and all of its subsidiaries and affiliates rendering care to the patient, whether or not affiliated with “Health Care Partners Foundation, Inc and MedXTrust.”

Authorization: I hereby authorize Health Care Partners Foundation, Inc and MedXTrust and all healthcare providers rendering care to me to obtain information from and to release information to each other and third parties (1) for the purpose of rendering services to the patient; (2) for the purpose of obtaining payment of any bills for any services or goods provided or to be provided to the patients, (3) for the purpose of conducting patient satisfaction surveys; and/or (4) for the purpose of verifying any information furnished by- or on my behalf (including credit and employment information).

Certification: I hereby certify that the information provided and to be provided by me to Health Care Partners Foundation, Inc and MedXTrust and all healthcare providers is and will be true and correct. I agree to pay any expenses incurred by Health Care Partners Foundation, Inc and MedXTrust and all healthcare providers because of incorrect information provided by me.

Acknowledgment: I acknowledge and agree as follows: (1) I am financially responsible for the charges for goods and services provided to patient that are not covered by third party payers, (2) at all times, I shall have the responsibility to determine and to meet the requirements of any third party payer, (3) where Health Care Partners Foundation, Inc and MedXTrust or any healthcare providers may provide advice and assistance to the patient, such advice and assistance shall not relieve
me of the absence of any express written agreement to the contrary and (5) in the event litigation is filled for nonpayment for charges, I agree to pay all expenses incurred by Health Care Partners Foundation, Inc and MedXTrust or any healthcare providers because of such litigation, including reasonable attorney’s fees and medical expert witness fees.

Third Party Payers

Insurance and Benefit Plans: I hereby assign, transfer and set over to Health Care Partners Foundation, Inc and MedXTrust all of my rights, title, and interest in and to medical reimbursement and/or payment and all my other rights and privileges, under any insurance policy or healthcare benefit plan private or public providing coverage for the services and goods provided by Health Care Partners Foundation, Inc and MedXTrust to patient.

Liability/Workmen’s Compensation Claims: If a third party is liable for any injury or disease for which the patient received treatment, then I hereby authorize and direct such, third party (and/or such party’s insurer) to make payment directly to Health Care Partners Foundation, Inc and MedXTrust and/or any healthcare provider rendering care to the patient for the charges pertaining to such treatment. I hereby assign and set over to Health Care Partners Foundation, Inc and MedXTrust and any healthcare provider the proceeds from any settlement or any payment or any claim that I have against third party to the extent that such proceeds or payment are attributable to the services and goods provided to the patient by Health Care Partners Foundation, Inc and MedXTrust or any healthcare provider.

Medicare: I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I assign the benefits payable
for covered services to Health Care Partners Foundation, Inc and MedXTrust and/ or any healthcare provider to the extent that they have provided covered services. I hereby grant to Health Care Partners Foundation, Inc and MedXTrust or
appropriate healthcare provider the right to apply my lifetime reserve days for this or other hospital stay.

Other Governmental Programs (including Medicaid, Tricare, etc.)

I authorize Health Care Partners Foundation, Inc and MedXTrust or any healthcare provider to obtain and to release the appropriate governmental agencies any information to qualify for any governmental benefit plan which might cover all or part of the charges incurred by me. I assign the benefits payable for covered services to Health Care Partners Foundation, Inc and MedXTrust or any healthcare providers to the extent that they have provided covered services. I acknowledge and agree that if, for any reason benefits are denied in whole or partly by any governmental agency, I shall pay the charges, which have not been covered.

By signing this agreement below, I acknowledge that:

- I have read this document and understand its contents I agree to this Agreement
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any question have been answered to my satisfaction and I verbally give my consent to have my electronic signature placed on this document on my behalf if I am unable to physically sign this document due to technical issues or physical impairment(s)
- I agree that I have provided correct and accurate information about the patient (including current address, telephone number, email address, insurance information, and medical history) for health care
- I understand that I have the right to have a copy of this Agreement The laws of the State of Colorado will apply to this Agreement
- In any legal action brought under this Agreement, I waive my right to trial by jury.
- I understand that no person working at Health Care Partners Foundation, Inc. and MedXTrust is allowed to change or erase any part of this document. Changes or anything that was added or deleted will not change the original (first) agreement, but that I've had an opportunity to ask questions about this Agreement and have received answers to such questions. I enter into this Agreement freely, knowingly, and voluntarily.

_____ _____

SIGNATURE/FULL NAME DATE/TIME

_____ _____

WITNESS SIGNATURE DATE/TIME