Sports Medicine and Performance Center

IN PARTNERSHIP WITH BOULDER COMMUNITY HEALTH

Waiver and Release of Liability—Read Before Signing

In consideration of being allowed to participate in any way in the Boulder Center for Sports Medicine coaching program, its related events and activities, I, _____, the undersigned, acknowledge, appreciate and agree that:

1. The risk of injuries from the activities involved in this program is significant, including the potential for permanent paralysis and death and while particular skills, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the Company immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE, INDEMNIFY AND HOLD HARMLESS Boulder Center for Sports Medicine, their officers, officials, agents and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable, owners and lessors of premises for the activity ("Releases"), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property associated with my presence or participation, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

X_____ Age_____ Date signed: _____

Participant's Signature

FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITY AGE

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of all the Releasees, and, for myself, my child and our heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, to the fullest extent permitted by law.

X_____ _____ Date signed: _____

PARENT/LEGAL GUARDIAN SIGNATURE (print name)

PATIENT CONSENT TO PHOTOGRAPH/VIDEOTAPE//INTERVIEW AND/OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:	**Birth Date:**
Person(s) or Class of Persons Authorized to Use/Disclose the Information:	**Person(s) or Class of Persons Authorized to Receive the Information:**

Individual consents to be:

□ Photographed □ Filmed □ Videotaped □ Interviewed □ Other

Purpose of Use/Disclosure: (Note: This item is not required if the disclosure is requested by the patient.)

□ Publication in newspaper(s), magazine(s) or other publications

□ Broadcast by radio or television

□ BCH marketing and public relations materials/publications □ Medical education

Description of Protected Health Information to be Used or Disclosed:

□ All Patient Identifying Information; or □ Age/Date of Birth □ City of Residence □ Nature of Injuries	□ Other:	□ Not applicable

I understand that, in the instance of external sources (such as media outlets or law enforcement agents), Boulder Community Hospital is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me.

As such, I relieve and hereby agree to hold Boulder Community Hospital free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Revocation notice should be sent in writing to the hospital's Public Relations Department, Mapleton Center, 311 Mapleton Ave., Boulder, CO 80304.
4. If the requester or receiver is not a health plan or health care provider, the released information may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
5. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Individual or Guardian:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Sports Medicine and Performance Center

IN PARTNERSHIP WITH BOULDER COMMUNITY HEALTH

Name: _____
DOB: _____

Financial Policies

Please read, initial and sign, indicating your understanding of the following information. If you have questions please do not hesitate to ask. It is important that you understand these specific policies of the Boulder Center for Sports Medicine and that you understand how your insurance company will handle your claims.

INITIAL:

_____ **It is your responsibility to provide the BCSM with current and correct insurance information.** Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

_____ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** The Boulder Center for Sports Medicine participates with most major medical insurance companies. We make every attempt to verify your benefits before your appointment and we will try to alert you if your plan restricts you from being seen here. However, Insurance companies frequently specify the number of visits and the time frame in which patients can be seen. If appointments are made that are not covered by your insurance plan, you will be responsible for payment.

_____ **If you have an outpatient hospital deductible, it will have to be met before your insurance will begin paying your claims**. The Boulder Center for Sports Medicine is an outpatient hospital facility. We do not always know if you have a deductible or if your deductible has been met. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible.

_____ **You will need to sign a self-pay waiver if you have no insurance or if you choose not to use your insurance coverage.** This waiver clarifies your financial responsibility and helps prevent misunderstandings.

_____ **Discounts are offered on some medical services, but ONLY if you pay at the time of service**. If you have no insurance, if you are receiving services that are not covered by your insurance plan, or if you choose not to use your insurance, you may be eligible for a discount on ***some medical services***. Payment must be made at the time of service for the discount to apply. The front office staff can let you know if the services you are receiving qualify for the discount. It is your responsibility to ask the front office for the discount.

_____ **If you have a co-pay, you are expected to pay this when you check in for your visits.** Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take checks, cash, and credit cards. Be prepared to pay your co-pay when you check in for **each** visit.

_____ **You will be charged $50-$100 if you fail to show up for your appointment or if you cancel your appointment with less than 24 hours notice.** Exceptions may be made for inclement weather. The correct number to call when canceling an appointment is 303-544-5700.

_____ **Supply Return Policy** – unopened, unused supplies may be returned within 30 days for a full refund. No returns will be accepted beyond 30 days. Used supplies may **not** be returned. Defective supplies may need to be returned to the manufacturer – contact us about defective merchandise.

I understand that the Boulder Center for Sports Medicine will need to use and disclose certain medical information about me as it relates to my treatment, payment for treatment and healthcare operations. The hospital has provided me with a Notice that describes how my medical information may be used and disclosed and how I can access this information.

_____ _____

Signature of Patient / Guardian **Date**

Please Keep This Information For Future Reference, ask for a copy if you wish.

Sports Medicine and Performance Center

IN PARTNERSHIP WITH BOULDER COMMUNITY HEALTH

PATIENT STICKER HERE

Cash Pay Waiver

☐ **No Insurance** – I do not currently have medical insurance and am not covered by Medicare or Medicaid programs. I choose to pay in full at the time of service (discounts may apply for some medical services if payment is made in full at the time of service). I understand that I cannot send my charges to any insurance company **if** I receive a self-pay discount.

☐ **No Benefits** – My current insurance may not cover certain services I may be receiving. If I choose to have these services, I agree to pay in full at the time of service (discounts may apply for some medical services if payment is made in full at the time of service). I understand that BCSM will not bill my insurance for these services and that I cannot submit my charges for these services to any insurance company. If eligible, I will receive a self-pay discount for these services (includes, but not limited to, Iontophoresis, compression ice, motion analysis, EMG studies, multiple modalities in one visit, among others).

☐ **No Prescription/Authorization** – I understand that my insurance requires a prescription and/or authorization for services I am receiving. I have chosen not to obtain this prescription/authorization and I am responsible for my charges. I choose to pay in full at the time of service (discounts may apply for some medical services if payment is made in full at the time of service). I understand that I cannot send my charges to any insurance company **if** I receive a self-pay discount.

☐ **Non-Contracted Insurance** – I understand that BCSM is not contracted with my insurance company. Therefore, I waive my insurance benefits and I choose to pay in full at the time of service (discounts may apply for some medical services if payment is made in full at the time of service). I understand that I cannot submit my charges to any insurance company **if** I receive a self-pay discount.

☐ **Waive Benefits** – I am electing not to use my insurance benefits for the services I am receiving, even though they may be a covered service or applied towards my deductible. I choose to pay in full at the time of service (discounts may apply for some medical services if payment is made in full at the time of service). I understand that I cannot submit my charges to any insurance company **if** I receive a self-pay discount.

☐ **Cash Pay Service** – I understand the services I am receiving today are not billable to insurance. I also understand that I must pay in full at the time of service. These services include, but are not limited to, Triage Appointments, Sports Massage, Performance Bike Fitting, Performance Gait Analysis, Nutrition Services, Coaching, Training, Sports Conditioning, and Performance Testing. I understand that I cannot submit my charges to any insurance company.

☐ **X-Rays** – If x-rays are requested and I have my x-rays performed here, I am responsible for these charges as well. X-rays may be applied to an outpatient hospital deductible. I will either supply my insurance information to the front desk **or** I will pay for these x-rays in full at the time of service (discounts may apply if payment is made in full at the time of service). I understand that I cannot submit my charges to any insurance company **if** I receive a self-pay discount.

Signature: _____ Date: _____

(This waiver is good for multiple dates of service pertaining to the diagnoses being treated at the time this waiver was signed, and the duration of treatment for these diagnoses.)