Red Rocks Community College Student Health Clinics

Patient Demographics / Consent for Treatment / Acknowledgement of Policies

Name_____ D.O.B_____ Student#_____

Address_____ _____ _____City_____ State_____Zip_____ _____

Phone Number_____ May leave message: Yes ☐ No ☐

Emergency Contact_____ Phone Number _____ Relationship_____

The following are conditions for services provided by the **Red Rocks Community College Student Health Clinics (RRCCSHC)** for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by **RRCCSHC** and its associated physicians, physician assistants, clinicians, and other personnel. I/we am/are aware that the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of examinations or treatments.

Acknowledgement of Receipt of Privacy Policy

I/we have been presented with a copy of the **Privacy Policy** for the **RRCCSHC** detailing how my information may be used and disclosed as permitted under federal and state law. I/we understand that I/we should read it carefully.

Acknowledgement of Payment Responsibilities

I/we understand that I/we am/are responsible for any charges not covered under the student health fee or employee co-pay as decided by the **RRCCSHC.** I/we guarantee payment of all charges at the time of service. I/we understand that I/we am/are responsible for the cost of all outside laboratory tests and medical imaging. I/we acknowledge that **RRCCSHC** is not liable for any fees that Colorado Laboratory Services, other lab companies, or imaging company charges and that these fees and charges will be billed directly to me/us.

Cancellation and No Show Policy

I/we understand that if unable to make a scheduled appointment, I/we must inform **RRCCSHC** as soon as possible and no less than one hour prior to the appointment. I/We understand that if I/we do not show up for the appointment I/we will be considered a "no show." If three "no shows" are acquired, I/we understand that my/our use and privilege of the **RRCCSHC** may be suspended.

Use and Privilege Policy

I/We am/are a current and registered Red Rocks Community College (RRCC) Student or Employee. I/We understand that use of the clinic is only permitted to registered RRCC students and employees. **RRCCSHC** reserves the right to suspend or terminate the patient/provider relationship for a period of time or for the duration of student enrollment or employement at RRCC at the provider's discretion. If I/we withdraw from the school, I/we understand that I may no longer seek treatment at the **RRCCSHC.**

Signed: _____ Date: _____

Patient Guardian Signature (if under 18 years old): _____
Relationship: _____ Date:_____