* 2025 SMMH Informed Consent and Patient Rights Agreement for Colorado

Sunflower Mountain Mental Health LLC
805 Eagleridge Boulevard, Suite 140
Pueblo, CO 81008
Phone: (719) 679-5022
Fax: (719) 888-1673

Patient Name: * ______________________

Patient Date of Birth: * ______________________

Informed Consent and Patient Rights Agreement for Colorado

Sunflower Mountain Mental Health (SMMH)

At Sunflower Mountain Mental Health ("SMMH" or the "Practice"), we are committed to providing compassionate, respectful, and equitable care to all patients. This document includes your informed consent for treatment, outlines your rights as a patient, and highlights important policies, including our compliance with the No Surprises Act and cash pay rates. Please review this agreement carefully.

1. Patient Rights

As a patient of SMMH, you have the right to:

A. Receive Information About Your Care: You have the right to receive clear and comprehensive information about your diagnosis, types and modalities of treatment, risks and benefits, and expected outcomes. You also have the right to ask questions and receive explanations to help you make informed decisions about your care.
B. Receive Medically Necessary Services: You have the right to receive services that are medically necessary and provided in the least restrictive setting appropriate to your needs.
C. Privacy and Confidentiality: Your health information is protected in compliance with HIPAA regulations and applicable Colorado state laws. We ensure the confidentiality of your records and communications, except as required or permitted by law. For more details, please refer to the separately signed SMMH HIPAA Notice of Privacy Practices.
D. Informed Consent: You have the right to receive clear, understandable information about your diagnosis, treatment options, associated costs, an explanation of the risks and benefits of proposed treatments, and to participate actively in the decision-making process regarding your care, enabling you to make informed decisions.
E. Non-Discrimination: You have the right to receive care without discrimination based on race, ethnicity, religion, gender, sexual orientation, disability, or other protected characteristics.
F. Participation in Your Care: You have the right to actively participate in decisions regarding your care, to refuse or discontinue treatment unless an emergency exists or a court order is in effect, and to seek a second opinion about your diagnosis or treatment plan, to the extent permitted by law.
G. Complaints and Grievances: You have the right to express concerns or file complaints regarding your care or experience without fear of retaliation. SMMH will address these concerns promptly and transparently. If you feel your concerns have not been adequately resolved, you may contact:
1. Office of Behavioral Health (OBH): Website, Phone: (303) 866-7400
2. Colorado State Grievance Board: Website, Phone: (303) 894-7800
H. Access to Records: You have the right to access your medical records in accordance with federal and state laws.
I. Advanced Directives: You have the right to create and update an Advanced Directive to outline your healthcare preferences in the event you are unable to make decisions for yourself. For more information:
1. Federal Resources: HHS Website
2. Colorado Resources: Advanced Directives Information
3. If you have questions or require assistance, please contact our office for guidance.

2. Informed Consent

I understand that it is my responsibility to review all associated policies provided by SMMH to ensure compliance and understanding of the terms of care. By seeking services at SMMH, I acknowledge and agree to the following regarding my care and responsibilities:

A. Understanding of Services: I have been informed about the nature, purpose, and potential risks and benefits of the psychiatric mental health and therapy services provided at SMMH, and I consent to receive treatment.
B. Attendance and Cancellation Policy: I understand that I am expected to adhere to the SMMH Attendance and Cancellation Policy, which outlines expectations for timely attendance and the process for canceling or rescheduling appointments. I agree to refer to this policy, provided to me separately, for full details.
C. Discharge/Termination and Communication Policy: I understand that SMMH may terminate services if I fail to adhere to clinic policies, including attendance requirements, safety guidelines, or payment obligations, as outlined in the SMMH Discharge/Termination from Practice and Communication Policy. I agree to refer to this policy, provided to me separately, for full details.
D. Treatment Limitations: SMMH is an outpatient psychiatric clinic and does not provide emergency or inpatient services. I understand the limitations of the services provided and agree to seek appropriate care during crises or emergencies. I also acknowledge that details regarding emergency services and crisis care are outlined in the Emergency Services Disclaimer section of this policy.
E. Communication and Technology: I consent to the use of electronic communication methods, understanding that while SMMH takes measures to ensure confidentiality, electronic communication carries inherent risks. For details, I agree to refer to the separately signed SMMH Telehealth Consent, Policy, and Agreement, the SMMH Discharge/Termination from Practice and Communication Policy, and the Email-Text Consent Policy for specific communication guidelines.
F. Controlled Substances: If my treatment plan includes the use of controlled substances, I understand that I must adhere to the terms outlined in the SMMH Controlled Substance Policy Agreement, provided to me separately. This policy includes expectations for proper use, refill procedures, and compliance with applicable laws.
G. Financial Responsibility: I understand and accept my financial responsibility for services rendered, including adherence to SMMH's payment policies. For details, I agree to refer to the separately signed SMMH Authorization to Bill Insurance and Authorization to Charge Non-Covered Fees Policy, as well as the SMMH Health Insurance Waiver if applicable.
H. Student Clinicians: Sunflower Mountain Mental Health (SMMH) is committed to supporting the education of future mental health professionals. As part of this commitment, student clinicians, practitioners, or interns may observe or participate in your care under the supervision of a licensed clinician. The involvement of students is designed to enhance your care while providing valuable learning experiences for future providers.
1. By signing this form, you acknowledge that you understand student clinicians may be present during your treatment and consent to
their involvement as part of SMMH's clinical practice.

3. Emergency Services Disclaimer

Sunflower Mountain Mental Health is an outpatient psychiatric clinic and does not provide emergency or inpatient services. SMMH communication methods are not monitored 24/7. If you are experiencing a medical emergency or crisis, please seek immediate assistance by:

A. Calling 911

B. Visiting the nearest emergency room

C. Contacting a crisis hotline:

1. Colorado Crisis Services: coloradocrisisservices.org, Phone: 844-493-8255, Text TALK to 38255

2. National Suicide Prevention Lifeline: Call 988

For ongoing care and treatment, please discuss appropriate resources with your provider during your next scheduled session.

4. No Surprises Act Information

In compliance with the No Surprises Act, SMMH provides the following assurances:

A. Good Faith Estimates: Uninsured or self-pay patients have the right to receive a Good Faith Estimate of expected charges for non-emergency services before receiving care. If the final bill is significantly higher than the estimate, patients have the right to dispute the charges by contacting SMMH directly or filing a formal dispute with the U.S. Department of Health and Human Services (HHS). If your final bill is significantly higher than the estimate, you have the right to dispute the charges.

B. Transparent Billing Practices: SMMH is committed to transparency in our billing practices. You may request a detailed explanation of your bill or charges at any time. For additional information regarding fees and financial responsibility, please refer to the SMMH Authorization to Bill Insurance and Authorization to Charge Non-Covered Fees policy, which you have signed separately, in addition to the SMMH Health Insurance Waiver if applicable.

For additional information on your rights under the No Surprises Act, visit the CMS Website at https://www.cms.gov/nosurprises.

5. Cash Pay Rates Information

For patients who choose to self-pay:

A. Rate Availability: Our cash pay rates are available upon request. Rates may vary depending on the provider and the type of service provided. Please contact our office for a detailed rate sheet.

B. Payment Terms: Payment for self-pay services is due at the time of service unless prior arrangements are made.

6. Federal and Colorado State Compliance

SMMH adheres to all relevant federal and Colorado state regulations to ensure the highest standard of care. This includes, but is not limited to, compliance with:

A. Patient confidentiality laws (HIPAA and applicable state laws).
B. Mandatory reporting requirements (e.g., abuse, neglect, or threats of harm).
C. Rights outlined by the Colorado Mental Health Practice Act.

7. Contact Details

If you have questions about this agreement or your rights as a patient, please contact us:

A. Phone: (719) 679-5022
B. Fax: (719) 888-1673
C. Email: contact@sunflowermountainmentalhealth.com
D. Address: 805 Eagleridge Boulevard #140, Pueblo, CO 81008

By signing below, you acknowledge that you have read and understood this Patient Rights Agreement. If you have any questions or concerns, please discuss them with our staff before signing.

Patient Signature (Patient if age 15+ or Parent/Guardian Signature, if applicable): * ______________________________

Parent/Guardian Name (if applicable): ______________________________

Relationship to Patient (if applicable): ______________________________

Date Signed: * ______________________________