

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. CONSENT FOR TREATMENT. I voluntarily consent to inpatient and/or outpatient care and treatment performed by my physician and all other health care providers at University of Colorado School of Medicine health care delivery sites. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider. I also understand that in the course of my medical treatment I may have one or more photographs of my skin or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive and I consent to this but I have the right at any time to object to letting such an individual observe and my objection will be honored. If this Patient Registration and Consent for Treatment is signed as part of an Emergency Department or other outpatient visit, it will continue for any related inpatient admission. I understand that if I am participating in a research protocol and have signed the Colorado Multiple Institutional Review Board (COMIRB) consent form, all provisions of this Patient Registration and Consent for Treatment shall apply to those tests and services not included within the research protocol.

2. AUTHORIZATION, FOR RELEASE OF INFORMATION. I authorize University of Colorado School of Medicine and its health care delivery sites to utilize confidential medical/Surgical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I further authorize the release and discharge of such confidential, information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an Acquired Immunodeficiency Syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me. I understand that if I am a participant in a human subject research protocol, my medical information may be further released to agencies and individuals identified in the COMIRB Subject Consent Form.

3. WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES. I understand that the University of Colorado School of Medicine or any of its health care delivery sites do not assume any responsibility for the loss or damage to my personal property.

4. PAYMENT AGREEMENT AND ASSIGNMENT. Except as prohibited by any agreement between my insurance company and The University of Colorado School of Medicine, University Physicians, Inc. (Faculty Practice Plan) or by state or federal law, I agree to be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I authorize The University of Colorado School of Medicine and University Physicians, Inc. to file any claims for payment of any portion of the patient bills and assign all rights and benefits to The University of Colorado School of Medicine and University Physicians, Inc. as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event The University of Colorado School of Medicine and University Physicians, Inc. take action to collect same because of my failure to pay in full all incurred charges. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

I have read this form, and by signing this form I understand and agree to what it says.
The consent for treatment shall be effective for (1) year.

Patient Signature

(Or parent/guardian/other authorized person
if Patient is a minor, mentally incompetent, or
physically unable to sign this form)

Date

Witness to signature

Printed name and relationship of person

**Reason Patient is unable to sign authorized
to sign for Patient**