University of Colorado Hospital
University of Colorado Denver
University Physicians, Incorporated
Rocky Mountain Gamma Knife Center, LLC

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the joint Notice of Privacy Practices for University of Colorado Hospital, University of Colorado Denver, University Physicians, Incorporated and Rocky Mountain Gamma Knife Center, LLC.

_____ _____
Name (Sign) Date

_____
Name (Print)

For Internal Use Only

Reason Acknowledgment was not obtained: _____

_____

_____

_____

_____ _____
Name (Sign) Date

_____
Name (Print)

UNIVERSITY OF COLORADO HOSPITAL ("UCH")
UNIVERSITY PHYSICIANS, INC. ("UPI")
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 UCH. I also consent to routine hospital services, diagnostic procedures, medical treatment, other services and hospital care as 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 UCH and UPI 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.** UCH maintains a safe for securing money and most other valuables. I understand that UCH does not assume any responsibility for the loss, damage, or disposal of my personal property unless such money or property is deposited in the safe. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the hospital.

4. **APPLICABILITY OF PATIENT REGISTRATION AND CONSENT FOR TREATMENT TO NEWBORN CHILD(REN).** I agree that the provisions of this Patient Registration and Consent for Treatment apply to any child(ren) who are born to me during my admission to UCH.

5. **PAYMENT AGREEMENT AND ASSIGNMENT.** Except as prohibited by any agreement between my insurance company and UCH, UPI 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 payors. I authorize UCH and UPI to file any claims for payment of any portion of the patient bills and assign all rights and benefits to UCH and UPI as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event UCH and UPI has to take action to collect same because of my failure to pay in full all incurred charges.

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

_____
Print Name and Relationship of Person Authorized to Sign for Patient

_____
Reason Patient is Unable to Sign

PATIENT STATUS

_____ Inpatient

_____ Outpatient

_____ ER