Specialty Outreach Clinics for Children
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO

In affiliation with Children's Hospital Colorado

# 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 either face to face or via telehealth. I understand I have the option to refuse the delivery of health services via telemedicine at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits. 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 I shall have access to all medical information resulting from the telemedicine services provide. 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***

*Attach Label*

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**University of Colorado School of Medicine &**
**University Physicians, Inc.**

## ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the University of Colorado School of Medicine and University Physicians, Inc. joint "Notice of Privacy Practices," available here: http://www.cudoctors.com/partners-affiliates/cu-specialty-outreach-clinics-for-children/cu-outreach-forms/

_____ _____
Name (Sign) Date

_____
Name (Print)

---

For Internal Use Only

Reason Acknowledgment was not obtained: _____

_____

_____

_____

_____ _____
Name (Sign) Date

_____
Name (Print)

*Attach Label*

University Physicians, Inc.

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# PATIENT RIGHTS AND RESPONSIBILITIES

**YOU HAVE THE RIGHT…**

- To be informed of your rights in advance of receiving or discontinuing care and to participate in the development and implementation of your plan of care.
- To request medically necessary and appropriate care and treatment.
- To be informed of your health status; to be involved in all decisions involving your care or treatment and to give informed consent for all treatment and procedures.
- To an examination to determine if you have an Emergent Medical Condition, treatment, and, if necessary, transfer to another facility if you have a medical emergency or are in labor, regardless of your ability to pay.
- To have a family member or representative notified promptly of your admission to a Hospital.
- To receive care or treatment that is courteous and respects your dignity.
- To privacy to the extent possible during your treatment.
- To be informed of clinic's policies and procedures.
- To be free from all forms of abuse or harassment.
- To receive care in a safe setting.
- To be informed if the clinic is participating in teaching programs, research and/or experimental programs.
- To request and receive, prior to the initiation of non-emergent care or treatment, the charge(s), or an estimate of the charges for routine, usual, and customary services and any co-payment, deductible, or non-covered charges, and the clinic's general billing procedures.
- To receive information from your physician concerning the recommended treatment or procedure, the risks and benefits of such treatment or procedure, the probability of success, mortality risks, serious side effects, the recuperative period, and consequences of no treatment.
- To confidentiality of your health information.
- To have an appropriate assessment and management of pain.
- To be informed of the clinic's grievance procedures and whom to contact to file a grievance or complaint.

**YOU HAVE THE RESPONSIBILITY…**

- To ask questions and promptly voice concerns.
- To be considerate of other patients and hospital personnel.
- To keep all appointments.
- To give full information as it relates to your care.
- To report all health changes.
- To follow instructions and the treatment plan recommended by your physician.
- To secure your belongings.

**TO FILE A CONCERN, COMPLAINT OR GRIEVANCE**

Please bring any concern, complaint or grievance to the immediate attention of the Clinic's Manager. As an alternate, a confidential hotline has been established and may be accessed at www.ethicspoint.com or by calling 866-ETHICS-P (866-384-4277).

If concerns are not resolved by the clinic to the patient's satisfaction you may also contact:

**The Colorado Department of Public Health & Environment**
Located at 4300 Cherry Creek Drive South, Denver, CO 80246-1530, (800) 886-7689 or (303) 692-2100
**The Colorado Board of Medical Examiners** (for concerns about physician services)
Located at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7690
**The Joint Commission** (for concerns over care or safety)
Located at One Renaissance Boulevard, Oakbrook Terrace, IL 60181, (630) 792-5000

**GOVERNMENTAL IMMUNITY NOTICE**

**Medical care or treatment at the University of Colorado School of Medicine health care delivery sites may be provided by individuals who are considered public employees by the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act, Article 10 of Title 24 of the Colorado Revised Statutes, limits the amount of damages recoverable from public employees *and* entities, requires a formal notice of claim, and places a 180-day time limit on the period for filing such a notice of claim.**

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# REGISTRATION INFORMATION REQUEST FORM

***In addition to this form please provide a copy of patient's current insurance card***

| **Patient Information** | | | | | |
|---|---|---|---|---|---|
| **Name** | | | | | |
| **Social Security #** | | | | | |
| **Date Of Birth** | | **Gender** | | **Marital Status** | |
| **Street Address** | | | | | |
| **City, State, Zip Code** | | | | | |
| **Phone Number** | | **County** | | | |

| **Patient's Physician Information** | | | |
|---|---|---|---|
| **Primary Doctor** | | **Phone** | |
| **Referring Doctor** | | **Phone** | |
| **Other Care Provider** | | **Phone** | |

| **Parent/Guardian/Responsible Person's Information** | | | | | |
|---|---|---|---|---|---|
| **Parent/ Guardian/Responsible Party (if not patient)** | | | | **Social Security #** | |
| **Parent/ Guardian/Responsible Party's Address** | | | | | |
| **City, State, Zip Code** | | | | | |
| **Employer 's Name** | | | | | |
| **Employer's Address** | | | | | |
| **City, State, Zip Code** | | | | | |
| **Home Phone** | | **Cell Phone** | | **Other Phone** | |

| **Please collect the following on CHAMPUS/TRICARE patients** | | | |
|---|---|---|---|
| **Sponsor's Duty Station** | | **Social Security #** | |
| **Sponsor's Branch of Service** | | | |
| **Sponsor's Status** | **Active Duty** ☐ **Retired** ☐ **Deceased** ☐ | | |
| **Sponsor's Grade/Rank** | | | |
| **City, State, Zip Code** | | | |

| **Insurance #1 Information** | | | |
|---|---|---|---|
| **Insurance Name** | | | |
| **Cert #** | | **Group #** | |
| **Insurance Address** | | | |
| **City, State, Zip Code** | | | |
| **Insurance Phone Number** | | | |
| **Subscriber** | | **Social Security #** | |
| **Relationship to Patient** | | **Date of Birth** | |

| **Insurance #2 Information** | | | |
|---|---|---|---|
| **Insurance Name** | | | |
| **Cert #** | | **Group #** | |
| **Insurance Address** | | | |
| **City, State, Zip Code** | | | |
| **Insurance Phone Number** | | | |
| **Subscriber** | | **Social Security #** | |
| **Relationship to Patient** | | **Date of Birth** | |

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# SELF-PAY AGREEMENT

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Specialty Outreach Clinics for Children and University Physician's Inc (UPI). Self-Pay patients/legal guardians should read this agreement carefully before making a decision and proceeding with care.

- Self-Pay patients/legal guardians will receive a bill from University Physicians Inc (UPI) for healthcare services provided by Specialty Outreach Clinics for Children
- A Self-Pay Agreement must be signed for each Specialty Outreach Clinics for Children account for which it applies
- Self-Pay patients/legal guardians will be required to make a minimum deposit at the time of service
- The patient/legal guardian will be responsible for full payment of charges, less the No Insurance Discount (NID) and less the deposit made at the time of service
- UPI will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be Self Pay at the time of service

**The No Insurance Discount (NID) does not apply to:**

- Patients that have insurance and select not to utilize their insurance
- Balances after all covered expenses or eligible services to be paid by a health benefits plan
- Amounts due according to the insurance plan Explanation of Benefits (i.e. deductible, co-insurance, and/or co-payment)
- Patients involved in grants or special programs, as these cases fall into a different set of circumstances

**The patient has been registered as Self-Pay due to the following reason marked below:**

- ❑ The patient/legal guardian does not have insurance coverage

**OR**

- ❑ The provider performing the above services or therapies is not a participating provider with my health insurance. There form these services/therapies are not covered by my policy
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ The scope of services rendered by this provider may not be covered by my health insurance policy
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ No claim will be sent to my insurance since it's my person decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/ therapies are considered covered by my policy (elected – self pay)

The patient/legal guardian elects to have their insurance billed first; the patient/legal guardian will be liable for all balances incurred after all eligible services and covered expenses to be paid by a health benefits plan. The No Insurance Discount (NID) will only apply if the patient's insurance plan does not cover any services.

***My signature below acknowledges receipt of the Self Pay Agreement***

Patient/Legal Guardian Signature Date

***Self-Pay Agreement Explained by:***

Staff Name (Print) Date

Attach Label

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# PATIENT HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by a medical provider of the University of Colorado School of Medicine. I understand that these services and/or therapies will be billed by University Physicians, Inc. I further understand I may be responsible for all charges incurred today for (service/cpt code) _____ by (provider)_____ ***even if I elect to have my insurance billed first.***

Estimate of UPI charges_____ (**this is only an estimate and may not be the full financial responsibility).**

❒ The **provider** performing the above services or therapies is **not a participating provider** with my health insurance. Therefore these services/therapies are not covered by my policy.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ The **scope of services** rendered by this **provider** may not be covered by my health insurance policy.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ The appropriate **authorization** required by my health insurance policy **has not been obtained** from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ No claim will be sent to my insurance since it is my personal **decision not to use my health insurance** benefits for the above service/therapy even though I understand that these services/therapies are considered covered by my policy. (Elective Self Pay)

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

_____ **Date** _____
**Printed Name and Relationship of Person Authorized to Sign for Patient**

_____
**Reason Patient is Unable to Sign**

**Insurance Waiver Explained by:** _____
**(Printed Name of Hospital or UPI Representative)**

_____ _____
**Signature of Hospital or UPI Representative** **Date**

Attach Label