University of Colorado
Anschutz Medical Campus
Hemophilia and Thrombosis Center

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT.** I voluntarily consent to outpatient care and treatment performed by my physician and all other health care providers at Hemophilia and Thrombosis Center (HTC) at the University of Colorado Denver. I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the health care providers treating me. I understand that the practice of medicine 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 treatment and to discuss it with my health care provider.
2. **RESEARCH.** I understand that if I am participating in a research protocol and have signed the Colorado Multiple Institutional Review Board (COMIRB) consent form, I am exempt from paragraphs 2 and 3 of this Patient Registration and Consent for Treatment with respect to the services specifically described in that research protocol. I understand that all provisions of this Patient Registration and Consent for Treatment shall apply to those tests and services not included within the research protocol**.** I understand that my medical information may be released to agencies and individuals identified in the COMIRB Subject Consent Form.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize the HTC, University Physicians Incorporated (UPI), University of Colorado (UCH), and Children's Hospital Colorado (CHCO) to utilize protected health information contained in my medical record as necessary for treatment, payment, or health care operations. I further authorize the release and discharge of such protected health information to my insurance company or other health coverage plan 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.
4. **MEDICARE, MEDICAID, OR COLORADO INDIGENT CARE PROGRAM.** I authorize any holder of medical or other information about me to release to the Social Security Administration, the Department of Health and Human Services, the Colorado Department of Social Services and their intermediaries, carriers or agents any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf.
5. **WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES.** I understand that HTC does not assume any responsibility for the loss of or damage to my personal property.
6. **PAYMENT AGREEMENT AND ASSIGNMENT.** 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, except as prohibited by any agreement between my insurance company and HTC, UPI or by state or federal law. I authorize HTC, UPI, UCH or CHCO to file any claims for payment of any portion of the patient bills and assign all rights and benefits to UPI as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event UPI has to take action to collect same because of my failure to pay in full all incurred charges.
7. **PHOTOGRAPHY.** I further authorize the HTC to take photographs/videos of _____ for the purpose of identification within HTC records, scientific and medical purposes and for use in medical and scientific publications and presentations. I understand that I will not receive financial compensation for their use. I understand that I may, at any time, make a written request to exclude use of said images. This is completely voluntary and up to me. ☐ Agree ☐ Disagree

By signing, I indicate that I have read and understand the terms of this Agreement. I agree to the terms stated above and am signing this Patient Registration and Consent for Treatment voluntarily. This 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

_____ _____

PRINT NAME (and relationship of person authorized to sign for patient if applicable)

Reason Patient unable to sign (if applicable)