

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 Associates in Obstetrics and Gynecology. I also consent to routine hospital services, diagnostic procedures, medical treatment, and 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 the right to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider.
2. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize Associates in Obstetrics and Gynecology 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 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 of care and treatment that has already been rendered to me.
3. **MEDICARE, MEDICAID, OR COLORADO INDIGENT CARE PROGRAM.** I authorize and holder of medical or other information about me to release to 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.
4. **PAYMENT AGREEMENT AND ASSIGNMENT.** Except as prohibited by any agreement between my insurance company and Associates in Obstetrics and Gynecology or by state or federal law, I AGREE TO BE RESPONSIBLE FOR MY CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES OR OTHER CHARGED FOR MEDICAL SERVICES NOT COVERED OR PAID BY INSURANCE OR OTHER THIRD PARTY PAYERS. I authorize Associates in Obstetrics and Gynecology to file and claims for payment of any portion of the patient bills and assign all rights and benefits to Associates in Obstetrics and Gynecology as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event Associate in Obstetrics and Gynecology 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.

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

Date