Campus Health Center
CU HEALTH PARTNERS
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

PATIENT INFORMATION AND REGISTRATION FORM

First Name_____ Last Name_____ MI_____ Sex_____

Date of Birth_____ SSN_____ Marital Status:_____

Mailing Address_____ City_____

State_____ Zip_____ Home Phone_____ Cell Phone_____

Email Address:_____

Emergency Contact_____ Phone_____ Relationship to Patient_____

Ethnicity (*circle one*): Hispanic or Latino Not Hispanic or Latino

Race (*check one*): ___White ___Black/African American ___Asian ___Hispanic/Latino
___American Indian/Alaska Native ___Native Hawaiian/Pacific Islander ___Other:_____

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 _____

PRIMARY INSURANCE INFORMATION

Do you have insurance? YES☐ NO ☐

Name of Insurance Company_____ ID/Policy #_____ Group#_____

Address of Insurance Company_____ Phone#_____

Policy Holder_____ Policy Holder's Date of Birth & SSN_____

Relationship to Patient_____

- Do you have a primary care provider? YES☐ NO☐ Name:_____ Phone:_____
- Have you traveled outside of the United States in the last month? YES☐ NO☐
- Have you been exposed to someone with an illness/disease you could catch? YES☐ NO☐

The following questions are optional and will be used by the CHC staff for planning and resource management purposes only.

1. Are you a student of the Anschutz Medical Campus? YES☐ NO☐ If yes, School/College/Program affiliation _____
2. Are you a faculty or staff member of the Anschutz Medical Campus? YES☐ NO☐ If yes, School/College affiliation?_____

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PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT.** I voluntarily consent to inpatient and/or outpatient care and treatment performed by all health care providers at University of Colorado Campus Health Care 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 Campus Health Care 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 Campus Health Care 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 Campus Health Care, 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 Campus Health Care 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 Campus Health Care 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 Campus Health Care 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 ***Date***
(Or parent/guardian/other authorized person if Patient is a minor, mentally incompetent, or physically unable to sign this form)

_____
Witness to signature

_____
Printed name and relationship of person to sign for Patient Reason Patient is unable to sign authorized

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University of Colorado Campus Health Center &
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 Campus Health Center and University Physicians, Inc. joint "Notice of Privacy Practices" effective September 23, 2013.

_____ _____
Name (Sign) Date

_____
Name (Print)

For Internal Use Only

Reason Acknowledgment was not obtained: _____

_____

_____

_____

_____ _____
Name (Sign) Date

_____
Name (Print)

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Patient Id Label

Health Information Exchange (HIE) Opt-Out/Opt-In Request Form

☐ I request that my health information not be viewable electronically through the University of Colorado Health System Information Exchange (HIE) system. I acknowledge that my information may still be transmitted as necessary to provide clinical care and for other purposes as required by law. I also understand that by opting out, my health information will not be available through the website in the case of an emergency.

I understand this request only applies to viewing my health information through the health information exchange system. I recognize that when I see a physician for treatment outside of the University of Colorado Health System, that physician(s) may request and receive my medical information from University of Colorado Health System through other methods permitted by law, such as fax, mail, or courier.

I am free to opt back in at any time and can do so by completing a Health Information Exchange (HIE) Opt-In Request Form that can be obtained from my health care provider.

A separate form must be filled out for each family member requesting to opt out.

☐ I previously submitted a request to "opt-out" of the Health Information Exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the system.

A separate form must be filled out for each family member requesting to opt back in.

Patient First Name:	Middle Name:
Patient Last Name:	
Previous Names or Nicknames:	
Date of Birth (mm/dd/yyyy):	
Mailing Address:	
City, State, Zip Code:	
Contact Phone Number:	

_____ _____

Signature of Patient (or authorized representative) Signature Date
If under 18 years, signature of parent/guardian