UCCS HealthCircle Primary Care Clinic
UNIVERSITY OF COLORADO COLORADO SPRINGS

4863 N. Nevada Ave
Colorado Springs, Colorado 80918
719-255-8001

Patient Name: _____Patient DOB:_____

Purpose of this Consent Form: This form is provided to patients of the UCCS HealthCircle Primary Care Clinic and Peak Nutrition Clinic (the "Clinic"). We want to let you know about the care and treatment that you will receive from the Clinic, and to obtain your consent to allow us to provide care to you, patients under the age of 18, or other individuals who may not be capable of making informed choices about their healthcare. We provide this form to you, parents, guardians or caregivers to evaluate and sign on behalf of the patient or self. In certain medical and behavioral health circumstances, patients under the age of 18 may complete this form.

General Consent and Conditions of Treatment: I consent to the treatment that will be provided by the Clinic primary care providers, as well as their assistants and other Clinic staff members. I understand that a medical record will be prepared and maintained about me by the Clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the Clinic for that purpose.

Student Participation: I understand that the Clinic participates in the education of students in healthcare. I can decline student participation in my care at any time.

Communication With Health Care Providers: To safeguard my health information, I understand that the Clinic's standard practice is to convey test results to patients by phone, web portal, mail (to the address provided by the patient or caregiver) or in person. I understand that the Clinic's policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the Clinic or make an appointment to come in to discuss my test results or health issues with a provider.

Health Information Exchanges: The Primary Care Clinic endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who participate in the program, and who are treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice at any time. I understand to opt out, needs to be in writing and presented by me to the Clinic.

The Clinic endorses, supports and participates in the Colorado Immunization and Information System (CIIS). CIIS is a confidential, computerized, system that collects and consolidates vaccination data for Coloradans of all ages and provides tools for designing and sustaining effective immunization strategies to prevent disease and reduce healthcare costs. Information in the CIIS system can be released only to individuals; individual's parent/legal guardian; individual's healthcare provider; a school or child care center where the individual is enrolled; health insurers if financially responsible for immunizations; healthcare organizations; or the Department of Health Care Policy and Financing for individuals enrolled in Medicaid. You may choose to opt-out of participation in the CIIS system or cancel an opt-out choice.

Emergency Situations: I understand that in emergency situations, it may be necessary or advisable for the Clinic to perform services and/or procedures that may not be fully discussed with me (or my parent or caregiver) in advance. I consent to these services and/or procedures under those circumstances.

Billing and Collection: I give the Clinic permission to share my information with my insurance company for purposes of seeking payment, as well as any third-parties that may be involved in billing or collection services for the Clinic. If I don't want certain information shared with my insurance company, I have the right to notify the Clinic before any billing takes place, but understand that I must also pay for the treatment that I do not want shared in full, at the time the treatment is provided, to avoid sharing the information with my insurance company. I understand that I am responsible for obtaining a referral or proper authorization with assistance from the Clinic staff from my insurance company for any procedures. I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that the Clinic is not responsible for interpreting these benefits. It is my responsibility to know which hospital and/or lab my insurance will reimburse for services. Specimens such as tissue biopsy samples, blood samples or urine will be sent to an outside lab contracted through my insurance company, in which case an outside charge may be associated with these services. I agree that if the insurance company denies benefits for any reason or if I have no insurance coverage, I will be responsible for the full amount of the service rendered. I understand to pay co-payments at the time the service. I understand and agree to pay a $30.00 fee for any returned checks.• I request that payment of authorized insurance/Medicare/Medicaid benefits be made to the Clinic (FEIN 84-6000555) for any services rendered. If these payments are not sent to the Clinic and sent directly to me, I agree to forward all insurance payments as soon as possible to the Clinic.

Authentication: I understand that the Clinic will require patients to provide identification in connection with visits to the Clinic or in connection with any telephone calls in which personal information may be requested. This helps the Clinic ensure that it is not divulging personal information nor treating an unauthorized person. If I cannot provide the necessary identification, I may not be able to receive treatment or receive the information that I am seeking from my medical record until I am able to satisfy the Clinic's authentication requirements. Such documents will include my valid driver's license and/or a picture I.D.

Personal Belongings: I understand that the Clinic takes steps to ensure that the waiting room and other areas of the Clinic are safeguarded. However, I understand that I am solely responsible for any personal belongings that I bring with me to the Clinic, including jewelry and other valuables.

Late Arrival/No Show: The Clinic makes every effort to see patients on time and give every patient their scheduled time with our providers. I understand that if I arrive 10 minutes late to my scheduled appointment, I may not be seen. I understand I may be charged a no show fee of $30 if I do not cancel my appointment 24 hours prior to my scheduled appointment.

Authorization to Release Information: I hereby authorize the UCCS Health Circle Primary Care Clinic to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care (to include behavioral health services); to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices.

Validity of Consent: I understand that this Consent Form shall be valid as long as I am a participant of the UCCS HealthCircle Primary Care Clinic. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the Clinic. The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent.

I HAVE READ OR HAD READ TO ME THIS CONSENT FORM, AND UNDERSTAND AND ACCEPT ITS TERMS.

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Patient Signature