Associates in Family Medicine, P.C.

Patient Name _____ Date of Birth _____

- Patients with Health Insurance should present their insurance card at each visit.
- Patients are responsible for payment of copay and coinsurance before each visit.

Informed Consent
I do hereby request and consent to the provision of health care services by the staff of Associates in Family Medicine. I understand that the services provided may include examinations, routine diagnostic tests, therapies, and other procedures which are determined to be advisable by, and are to be rendered by or under the general or special supervision of a physician.

I acknowledge that no guarantees have been made to me as to the result of the examinations, treatments, or therapies provided in the Clinic.

Authorization to Release Information
I authorize Associates in Family Medicine to release all medical information necessary to secure payment of insurance benefits and to use my signature below on all insurance submissions. If this visit is due to a work-related injury, I authorize Associates in Family Medicine to release verbal and/or written medical information regarding my injury (ies) to my employer and/or my employer's worker's compensation insurance carrier.

Authorization to Pay Benefits to Physician
I directly assign all insurance benefits, if any, to Associates in Family Medicine for services rendered to the patient.

Authorization of Financial Responsibility
I agree to accept personal responsibility for all medical expenses incurred and shall be responsible for the full amounts of any bill or portions thereof which my insurance company does not pay.

CORHIO
I understand that my health information will be exchanged electronically with other healthcare providers through **Colorado Regional Health Information Organization** (CORHIO) and acknowledge that I may change my participation status at any time by going to www.corhio.org.

_____ _____
Signature of Patient/Guardian/Patient Representative **Date**

OPTIONAL: **Medical Information Sharing and Disclosure**
I authorize Associates in Family Medicine to share or disclose any and all of my medical information with those individuals listed below (checked boxes only):
This authorization is valid for 1 year from date of signature unless otherwise indicated. _____
To revoke this authorization, either complete a Revocation of Authorization Form or provide written communication to the office.

□ Spouse: Full name _____

□ Both Parents: Full names _____

□ One Parent: Full name _____

□ Other: List full name _____

_____ _____
Signature of Patient **Date**