Colorado Childrens Medical Group (CCMG)
Financial Agreement and Patient Consent

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:
I understand that I am financially responsible and agree to pay all of CCMG's charges and any related charges that are not paid by insurance or any other third party payer. I authorize payment directly to CCMG for all benefits otherwise payable to me I UNDERSTAND THAT IF I DO NOT PROVIDE ALL OF THE REQUSTED/NECESSARY INFORMATION, I WILL BE BILLED DIRECTLY FOR ALL CHARGES UNTIL SUCH INFORMATION IS PROVIDED.

RELEASE OF INFORMATION
I authorize CCMG and my practitioner(s) to release (verbally or in writing) confidential medical, psychiatric and/or psychological information contained in my medical record to my employer, (workers' compensation only) and/or to any person or entity which may be liable to me, CCMG or my Practioner(s) for chargers for this treatment, and for quality management/utilization review, discharge planning, transfer and follow-up purposes. I understand that following the release of this information, CCMG and its Practitioner(s) cannot control its confidentiality. I understand this release of information is subject to revocation at any time except to the extent that CCMG or practitioner(s) have already taken action in reliance on it. If not previously revoked in writing, this consent will terminate (1) year from date this agreement is signed.

CONSENTS AND DISCLOSURES:
I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instructions of the attending practitioner(s) care and service or the practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at CCMG. I understand that CCMG encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care. NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT, AND ACCEPT ITS TERMS.

Signature of Patient/ Responsible Person X_______________________

Relationship (if other than Patient)_________________Date_________

Witness (to signature only)________________________Date_________