COLORADO PULMONARY ASSOCIATES, P.C.

Waiver of Liability

CONSENT TO MEDICAL CARE: By my signature below, I warrant that I am the patient or patient representative. I hereby request and authorize the physician and other health care providers of Colorado Pulmonary Associates, P.C. and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services for myself at the office of Colorado Pulmonary Associates, P.C.. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of Colorado Pulmonary Associates, P.C.

FINANCIAL AGREEEMENT AND GUARANTEE: I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make such payments in accordance with the payment policies of Colorado Pulmonary Associates, P.C. or in the event of default of my financial obligation to pay for services rendered, Colorado Pulmonary Associates, P.C. may terminate the "doctor-patient" relationship with the registered patient(s). Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

CORRECT INFORMATION: The undersigned certifies that he/she has provided correct information in this Patient Registration Form and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, duly authorized to execute the above and to accept its terms.

CO-PAYS: must be paid at the time of each visit. This is the policy of your insurance company, which our office is required to comply with.

RELEASE OF MEDICAL RECORD INFORMATION. I hereby authorize Colorado Pulmonary Associates P.C. to disclose all or any part or the contents of the medical record of the patients named on the registration form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

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Signature of Patient Date