DIRECT PAYMENT AUTHORIZATION AND CONSENT FORM
ANDY FINE, M.D.
7720 S. BROADWAY, SUITE G30
LITTLETON, CO 80122

Name of Patient (Print)
Last:_____First:_____MI:_____

AUTHORIZATION FOR MEDICAL EVALUATION:
I hereby authorize Andy Fine, MD to evaluate my medical condition at my initial consultation appointment and any treatment or follow up appointments as deemed necessary.

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION:
I consent that information contained in my medical record may be furnished to any insurance carrier, hospital service corporation or medical expense indemnity company, which may be liable for my medical expenses under a specific contract. Such information shall be confidential. I also consent to communication between Andy Fine, MD and my other healthcare providers.

AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to Andy Fine, MD of any Insurance Benefits payable to me but not to exceed the regular and customary charges for the services. I hereby assign, transfer, and set over sufficient monies and/or benefits to cover the cost of care rendered to me or my dependents and authorize payment to the physician directly. I understand that I am financially responsible for any amounts not covered by my plan or this authorization.

MEDICARE BENEFITS:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim. I request that payment under the Medical Insurance Program be made to Andy Fine, MD for services provided to me.

FINANCIAL AGREEMENT:
I, the undersigned, agree that in consideration for the services rendered to me, that I am fully responsible for the full amount of the bill (charges). Should my account be turned over for collection, I agree to pay all attorney fees including any fee over and above that of the bill. Interest may be charged at the IRS legal rate should my account become delinquent.

I, the undersigned, certify that I have read the foregoing, understand, and accept its terms.

Signed:_____Date:_____

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