Andy Fine, MD
7720 S Broadway Suite G30
Ph: 303-703-8583 Fax: 303-703-9791

PATIENT DEMOGRAPHICS

Last Name:		**First:**	**M.I**
Street:			**PO Box**
City:		**State:**	**Zip +4**
Home Phone ( )		**Work Phone ( )**	
Sex: M F	**DOB: / /**	**Age**	**Social Sec # _____-_____-_____**
ETHNICITY: (Please Check One) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline	**RACE:**		**PREFERED LANGUAGE:**
Your Current Status? Employed Comp or disability **Retired Date** _____ Student Other			**Marital Status** Single Married Divorced Widowed
Employer (Current even if on DBL)		**Job Position:**	
EMAIL ADDRESS:			**REFERRAL SOURCE:**

Spouse or other Guarantor Information

Last Name		**First**	**MI**
Street **Write SAME if same as above**			**PO Box**
City ____ ____		**State**	**Zip +4**
Home Phone ( )		**Work Phone ( )**	
Your Current Status? Employed Comp or Disability **Retired Date** _____ Student Other			**Soc Sec # _____-_____-_____**
Employer	**City**		**State** **Zip**
Sex: M F	**Birthday: Mo Day Year**	**Age**	

Patient Signature Date

Updated 3/12/13

DR ANDY FINE M.D
7720 S BROADWAY SUITE G30
LITTLETON, CO 80122
PH: 303-703-8583 FAX: 303-703-9791

Acknowledgement Of Receipt Of Privacy Notice

I acknowledge receipt of the Privacy Notice.

Patient Name (print): _____

Provider: **DR ANDY FINE M.D.**

At times our office may contact you:

- *As a reminder that you have an appointment*
- *For questions regarding the payment of your care.*

Please list those individuals you authorize to receive this information on your behalf.

_____

_____

Sign/Patient or Representative: _____

Date: _____

Patient Representative: (print): _____

Describe your authority: _____

Documentation of Good Faith Efforts

The patient presented to our office on this date and was provided with a copy of our Privacy Notice. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign or initial.

☐ Patient was unable to sign or initial because:

_____

☐ There was a medical emergency
(The office will attempt to obtain Acknowledgement at the next available opportunity).

☐ Other reason, describe below.

_____

Signature of Employee Completing Form Date

_____

Printed Name of Employee

Andy Fine, M.D., P.C.

Patient Name DOB Drug allergies:

Do you, or any blood relatives, have any of the following? (& who?)

	You this column	**Family in this Column** (living or deceased)
Diabetes		
High Blood Pressure		
Elevated Cholesterol		
Heart Disease / Heart Attack		
Strokes		
Depression		
Anxiety		
Thyroid Disorders		
Respiratory Problems (& type)		
Cancer (& type)		
Neurological Problems		
Any Additional Diagnoses		

Name & Age of: Mother Father

Siblings

Please list your medications: (or provide list)

Do You:	**Now**	**History (start & end dates)**
Exercise Regularly?(what?)		Frequency?
Follow A Particular Diet?		Which?
See a Doctor Regularly?		
Use Tobacco?		Amount?
Alcohol Consumption		Amount?
Illicit Drug Use		Amount?
Have Hobbies?		What?
Work?		Doing What?

Please list your other physicians:

Your Surgical History:

Please provide the month & year (or approximate) of your last:

Tetanus vaccine (Or, was it within the last 8 yrs?): **Pneumonia vaccine** (within the last 5 yrs?):

Physical: Mammogram: Ever abnormal? / Pap Smear: Ever abnormal?

Bone Density Study: **Findings?** **Next due?** **/ Stress Test:** **Findings?**

Colonoscopy: **Findings?** **Next due?** **/ Other:**

Purpose of today's visit:

Online Communications Informed Consent

For online communications with: Dr. Andy Fine, M.D.

Instructions for Using Online Communications

You agree to take steps to keep your online communications to and from Dr. Fine confidential including:

- Do not store messages on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.
- Use screen savers or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third party access to the computer(s) upon which you store medical messages or other personal medical information.
- If you have or learn of any personal email addresses that Dr. Fine uses, you will not use them for medical communications. Standard email lacks security and privacy features and may expose medical communications to employers or other unintended third parties.
- Withdrawal of this informed consent must be done by written online communications or in writing to Dr. Fine's office.

Use good communications etiquette:

- Confirm that your name and other personal information in the messages is correct.
- Review the message before sending it to make sure that it is clear and that all relevant information is included.
- Update your contact information on the network as soon as it changes including any changes to your regularly used email address. Dr. Fine will not use your standard email account for security reasons, but notifications are sent to your standard email address when a message has been sent to you and is waiting for you in your secure mailbox.

Charges for Using Online Communications

Dr. Fine's office may charge for certain online communications. You will be informed in advance when/if these charges apply and you will be responsible for payment of these charges if you accept and use any fee-based service. You may choose to contact your insurance carrier to determine if they cover online communications.

Conditions of Using Online Communications

The following agreements and procedures relate to online communications:

- Dr. Fine's office will print out a copy of all medically important online communications and include it in your medical record. This means that appropriate members of his staff will have access to these communications as part of our medical records keeping treatment and billing.
- You should print or store (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
- Dr. Fine will not forward online communications with you to third parties except as authorized or required by law.
- You agree to follow the procedures that Dr. Fine implements that will allow him to verify your identity in connection with online communications and you

acknowledge that failure to comply with these procedures may terminate our online communications.

- Online communications will be used only for limited purposes. It cannot be used for emergencies or time-sensitive matters. It should be used with caution. It should not be used to communicate highly sensitive medical information such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.) If there is other information that you don't want transmitted via online communications, you must tell him.
- Dr. Fine will make every attempt to respond within the timeframe he has designated. However, there may be times when this is not feasible, and you understand and agree to accept variations in response times and use other forms of communications with his office and Dr. Fine if online responses are not satisfactory to you. Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools.
- While Dr. Fine will take reasonable precautions to protect your information, Dr. Fine is not liable for improper disclosure of confidential information unless it was caused by his intentional misconduct.
- Follow-up is your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communication wasn't received.
- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. Dr. Fine is not responsible for breaches of confidentiality caused by you or an independent third party.
- Dr. Fine will not engage in any illegal online communication, including illegally practicing medicine across state lines.

Access to Online Communications

The following pertains to access to use of online communications:

- Online communication does not decrease or diminish any other ways in which you can communicate or see Dr. Fine. It is an additional option and not a replacement. You are encouraged to contact Dr. Fine's office via telephone, mail or in person, as always, if you have any questions or needs.
- Dr. Fine alone will decide which medical topics are appropriate for online communications and with whom Dr. Fine communicates online.
- Dr. Fine may stop providing online communications with you or change his online services provided at any time without prior notification to you.

Risks of Using Online Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks. These risks include, but are not limited to:

- Online communication may travel much farther than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
- Online communications is easier to falsify than handwritten or signed hard copies. A dishonest person could attempt to impersonate you to try to get your medical records.
- It is harder to get rid on an online communication. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
- Online communication is not private simply because it relates to your own medical information. Dr. Fine uses a secure network to avoid using standard email or email systems provided by employers. Employers and online services have a right to inspect and keep online communications transmitted through their system.
- Online communications are also admissible as evidence in court.
- Online communications may disrupt or damage your computer if a computer virus is attached.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers.

Patient name: _____

Patient signature: _____

Date: _____

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 (if applicable):
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:_____