Patient Interview Form

Patient Information

First Name:________ Last Name:________
MRN:________ Date Of Birth:________
Age:________ Notes:________

Allergies

⬭ Patient has no known allergies ⬭ Patient has no known drug allergies

⬭ Latex ⬭ Codeine ⬭ Penicillins ⬭ Sulfa (Sulfonamides) Other:________

Other:________ Other:________ Other:________ Other:________

Current Medications

⬭ None

Name	Dose	How taken?

Past or Present Medical Conditions

⬭ None

Group 1

⬭ Diarrhea When:________
⬭ Change in bowel habits When:________
⬭ Colon cancer When:________
⬭ Colon polyps When:________
⬭ Abdominal pain When:________ Other:________
⬭ Heartburn When:________ Other:________
⬭ Weight loss When:________ Other:________
Other:________
Other:________

Diagnostic Studies/Tests

⬭ None

Other:________

Previous Procedures

⬭ None

Social History

Occupation: ____________________ Number of Children: ____________________

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union
- ◯ Unknown
- ◯ Other

Alcohol

◯ None

Caffeine

◯ None

Tobacco

◯ None

Drug Use

◯ None

Exercise

◯ None

Family Medical History

◯ No knowledge of family history

No family history of

Health Status	Mother	Father	Sister	Brother	Maternal Grand Mother	Paternal Grand Mother	Maternal Grand Father	Paternal Grand Father
Cause of Death	____	____	____	____	____	____	____	____
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Other Cancers:	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯
Strokes	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯	◯	◯

Review Of Systems

Constitutional (Yes / No)
- None
- fatigue
- fever
- chills
- weight loss
- weight gain
- loss of appetite
- malaise
- sweats

Neurological (Yes / No)
- None
- weakness
- numbness or tingling
- dizziness
- fainting
- frequent headaches
- migraine
- seizures
- tremors
- vertigo

ENMT (Yes / No)
- None
- vision changes
- redness
- difficulty swallowing
- dizziness
- double vision
- ear pain
- loss of vision
- nasal obstruction
- nose bleeds
- photophobia
- sore throat

Integumentary (Yes / No)
- None
- allergies
- rashes
- dryness
- hives
- itching
- jaundice
- lesions

Genitourinary (Yes / No)
- None
- prostate
- kidney diseases
- dark urine
- decrease in urine flow
- dysuria
- frequent urinary infections
- frequent urination
- hematuria
- impotence
- nocturia
- urethral discharge or incontinence

Endocrine (Yes / No)
- None
- Diabetes
- Thyroid
- excessive thirst
- hair loss
- heat intolerance

Gastrointestinal (Yes / No)
- None
- constipation
- diarrhea
- nausea
- abdominal pain
- abdominal swelling
- change in bowel habits
- gas
- heartburn
- vomiting
- jaundice
- rectal bleeding
- stomach cramps

Allergic/Immunologic (Yes / No)
- None
- HIV exposure
- persistent infections
- strong allergic reactions or urticaria

Psychiatric (Yes / No)
- None
- anxiety
- depression
- difficulty sleeping
- hallucinations
- nervousness
- panic attacks
- paranoia

Respiratory (Yes / No)
- None
- asthma
- cough
- dyspnea
- excessive sputum
- hemoptisis
- shortness of breath with exercise
- wheezing

Hematologic/Lymphatic (Yes / No)
- None
- bleeding gums or palpable lymph nodes
- easy bruising
- prolonged bleeding

Cardiovascular (Yes / No)
- None
- chest pain
- dyspnea with exercise
- irregular heart beat
- orthopnea
- palpitations
- peripheral edema
- syncope

Musculoskeletal (Yes / No)
- None
- arthritis
- back pain
- gout
- joint deformity
- joint pain
- muscle weakness
- stiffness

Pharmacy

Name: ______________________

Reviewed with

- Patient
- Parent
- Guardian
- Not Present

PATIENT INFORMATION SHEET

Patient Name:______________________________ SSN#______________

Address:____
STREET CITY STATE ZIPCODE

Date of Birth:______________ **Gender**(please circle): M F **Status:** Married Single Divorced Widowed

Please check the box if you would prefer us **NOT** to contact you at the below numbers/address

☐Home Phone # : ______________

☐Work Phone # : ______________

☐Cell Phone # : ______________ ☐**Email Address**: ______________

Emergency Contact (Name/Telephone #):______________________________

Primary Care Physician (First/Last Name):______________________________

Referring Physician (First/Last Name):______________________________

I authorize the physician or anyone acting on his/her behalf to leave pertinent messages for me regarding my medical condition on my answering machine and/or voice mail.

(Please circle one) Yes No

Financially Responsible Party *(If Different From Patient)*

Last Name:______________ First Name:______________ MI:______

Street Address:______________City:______________ State:______

Home Phone:______________Work Phone:______________ SS#______________

Date of Birth: Relationship to Patient: Gender: M F

Insurance Information *(Must be completely Filled Out)*

Primary Insurance Co Name:	**Secondary** Insurance Co Name:
Insurance Co Address:	Insurance Co Address:
Patient's Insurance Policy #:	Patient's Insurance Policy #:
Patient's Group #:	Patient's Group #:
Insured's Name:	**Insured's Name:**
Insured's SS#:	**Insured's SS#:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Insured's Employer Name:	Insured's Employer Name:
Insured's Employer Phone #:	Insured's Employer Phone #:
Patient's Relationship to Insured:	Patient's Relationship to Insured:

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I hereby authorize payment directly to the physician/facility for all insurance benefits otherwise payable to me.

Signature:______________________________ Today's Date:______________

FINANCIAL POLICY AND PATIENT AGREEMENT

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Gastroenterology Associates of Colorado Springs, LLP, Pikes Peak Endoscopy & Surgery Center, LLC and Briargate Endoscopy Center, LLC. Please be advised that Pikes Peak Endoscopy & Surgery Center and Briargate Endoscopy Center are owned and operated by the physicians of Gastroenterology Associates of Colorado Springs, LLP and are fully accredited surgery centers by AAAHC, Medicare approved and licensed by the state of Colorado.

CUSTOMER SERVICE: If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (719) 477-0755. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a $25.00 service charge on all returned checks.

APPOINTMENTS: Please arrive at least 30 minutes prior to your appointment to give yourself time to update your records or complete paperwork required by your insurance. In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment so that we can accommodate another patient's needs. If you fail to cancel or reschedule within **24 hours of your office visit**, you will be billed $25.00 for that visit. If you fail to cancel or reschedule within **72 hours of your scheduled procedure**, you will be billed $50.00 for that missed procedure appointment.

INSURANCE FILING: As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).

HMO/PPO: If we have an agreement with your insurance carrier, we will receive direct payment for covered services. Co-payments are due at the time of service. Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and is your responsibility to obtain one. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. If you are having a procedure performed at Pikes Peak Endoscopy & Surgery Center or Briargate Endoscopy Center and a pre-certification for that procedure is required, we will obtain authorization for that procedure on your behalf. If your insurance company does not authorize the procedure, you will be notified of your financial responsibility prior to the procedure being performed.

INDEMNITY-TYPE INSURANCE: Your insurance may or may not agree with the UCR (usual, customary and reasonable) charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. You will be responsible for any remaining balance on your account once your insurance has processed our claim.

Billing Statements: Our statements are sent monthly. We allow 60 days for your insurance company to respond to our claim. If they have not responded in that time frame, we will send you a bill for the outstanding amount and ask that you begin making payments on your account while you resolve any payment issues with your insurance company.

Copies of Medical Records: We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. We do not charge patients for copies of their own records. Fees for copying records requested from business' are as follows: $14.00 for 10 or fewer pages, 50 cents per page for pages 11-40 and 33 cents per page after 40 pages.

By signing below, I am recognizing that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company.

Patient Signature	Witness Signature	Date

Gastroenterology Associates of Colorado Springs *Telephone: (719) 632-7101*

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW GASTROENTEROLOGY ASSOCIATES OF COLORADO SPRINGS, PIKES PEAK ENDOSCOPY AND SURGERY CENTER AND BRIARGATE ENDOSCOPY CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center or received by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may determine that you require the services of a specialist. In referring you to another doctor, Gastroenterology Associates of Colorado Springs/ Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits of health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of service to be provided to you.

For example, Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use your diagnosis, treatment, and outcome information to measure the quality of the services we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designed in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- **As permitted or required by law.** In certain circumstances, we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- **For public health activities.** We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request for that agency. We are required to report positive HIV test

results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- **For health oversight activities.** We may disclose healthcare records, including treatment records, in response to a written request by any federal or state or governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable disease.
- **Judicial and Administrative Proceedings.** Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- **For activities related to death.** We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- **For research.** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- **To avoid a serious threat to health or safety.** We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- **For workers' compensation.** We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center, please contact the Privacy Officer at the following:

Privacy Officer
Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center
1699 Medical Center Point
Colorado Springs, CO 80907
Telephone: (719) 632-7101   Fax: (719) 632-4468

It is the policy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

[1] This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I______________________________ acknowledge that I have received a copy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and/or Briargate Endoscopy Center's Notice of Privacy Practices. This Notice describes how Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and Briargate Endoscopy Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

___________________________________ ___________

Signature of Patient or Representative **Date**

____

Relationship to Patient

Online Communications Informed Consent

For online communications with Gastroenterology Associates of Colorado Springs/Pikes Peak Endoscopy/Briargate Endoscopy

Instructions for Using Online Communications

You agree to take steps to keep your online communications to and from me 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 I use, 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 my office.

Use good communications etiquette:

- Confirm that your name and other personal information in the message 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. I do 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

My 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:

- My 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 my 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.
- I will not forward online communications with you to third parties except as authorized or required by law.
- You agree to follow the procedures that I implement that will allow me 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 me.
- I will make every attempt to respond within the timeframe I have 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 my office and me 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 I will take reasonable precautions to protect your information, I am not liable for improper disclosure of confidential information unless it was caused by my 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. I am not responsible for breaches of confidentiality caused by you or an independent third party.
- I 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 and use of online communications:

- Online communication does not decrease or diminish any other ways in which you can communicate or see me. It is an additional option and not a replacement. You are encouraged to contact my office via telephone, mail or in person, as always, if you have any questions or needs.
- I alone will decide which medical topics are appropriate for online communications and with whom I communicate online.
- I may stop providing online communications with you or change my 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 each time you plan to communicate with me, and communicate in such a fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:

- Online communication may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
- Online communication 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 of 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. I use 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: ______________________________