



DIGESTIVE HEALTH ASSOCIATES of Cheyenne

7212 Commons Circle
Cheyenne, WY 82009

Phone: 307-635-4141
Fax: 307-638-2656
www.dhawy.com



Wyoming Endoscopy Center

7220 Commons Circle
Cheyenne, WY 82009

Patient Name _____

Date of Birth _____

Insurance Information:

Primary Insurance _____ Insurance Phone: _____

Insured Party: Self Spouse Parent Other (please specify) _____

Name of Subscriber _____ Date of Birth _____ SSN _____

Member ID _____ Group _____ Effective Date _____

Claims Billing Address _____ City _____ State _____ Zip _____

Secondary Insurance:

Primary Insurance _____ Insurance Phone: _____

Insured Party: Self Spouse Parent Other (please specify) _____

Name of Subscriber _____ Date of Birth _____ SSN _____

Member ID _____ Group _____ Effective Date _____

Claims Billing Address _____ City _____ State _____ Zip _____

Emergency Contact Information:

Name: _____ Relationship _____

Telephone Home _____ Work _____ Cell _____

How did you hear about Digestive Health Associates: _____

Referred by: _____

I hereby authorize medical treatment of the above named patient and agree to be financially responsible for all charges for such treatment, including cost of collection and legal fees (if applicable). I hereby assign payments to Digestive Health Associates. I authorize Digestive Health Associates to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient/Guardian Signature _____ Date _____



Review of Systems / Past Medical History

Patient Name _____

Date of Birth _____

Please mark the conditions that apply:

General:

- | | | |
|--|--|--|
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Less interest in doing things |
| <input type="checkbox"/> Weight Loss(amount _____) | <input type="checkbox"/> Cancer _____ | |
| <input type="checkbox"/> Weight Gain(amount _____) | <input type="checkbox"/> Diabetes (Diagnosed when _____) | |

Eyes, Ears, Nose & Throat:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Cataracts |

Lungs

- | | | |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Shortness in breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | |

Heart:

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Blood Clots |

Skin:

- | | | |
|---------------------------------|---|----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Allergic Reactions/Hives | <input type="checkbox"/> Growths |
|---------------------------------|---|----------------------------------|

Urinary:

- | | | |
|---|---|--|
| <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Urination at Night | <input type="checkbox"/> Decrease in Urine Force or Flow |

Bones and Joints

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Weak Bones |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Swollen Joints |

Neurological/Psychiatric:

- | | | |
|--|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tremors/Hands Shaking | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Anxiety |

Gastronintestinal:

- | | | |
|---|--|---|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Changes in Bowels |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Bloating | |

Additional information you feel is important: _____

Medication/Allergy Review and Family History

Patient Name _____

Date of Birth _____

Medications: (please list if not attached)

Medication Name:	Dose	Frequency

Allergies: (please list if not attached)

Name of Allergen	Reaction

Family history of colon cancer, please list maternal or paternal blood relative if applicable:

	YES / NO	If yes, whom	Age of onset
History of Colon Cancer			
History of Colon Polyps			

Other GI Surgical procedures not listed: _____

Please list any lab or radiological testing performed within the last year and where they were performed:



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Authorization to Release Medical Information

Patient: _____
SSN: _____ Date of Birth _____

I authorize Digestive Health Associates to discuss information associated with my medical care and treatment with (i.e. spouse, sibling, friend):

Name	Relationship

INFORMATION TO BE SHARED (please check all that apply):

- | | |
|--|--|
| <input type="radio"/> Admission history and physical
<input type="radio"/> Discharge Summary
<input type="radio"/> Complete hospital chart
<input type="radio"/> Office notes
<input type="radio"/> Psychiatric and other mental health records
<input type="radio"/> Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contains information relating to me.
(These records should be redacted to protect information pertaining to other patients) | <input type="radio"/> Lab Reports
<input type="radio"/> Radiological Reports
<input type="radio"/> Consultation notes or reports
<input type="radio"/> Outpatient records |
|--|--|

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric care, and treatment of alcohol and /or drug abuse; my signature authorizes release of any such information.

This authorization is valid and in force until revoked. I understand that I can revoke this authorization at any time by writing to the health care provider but revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand:

- I am not required to sign this authorization and that my health care or payment will not be affected by my refusal
- Federal privacy regulations will no longer apply to the information disclosed, and that Digestive Health Associates may re-disclose the information
- I am entitled to receive a copy of this authorization
- A copy of this authorization may be utilized with the same effectiveness as the original

Patient or Representative Signature Date

Witness to Signature Date

Name of Representative, if required (print)

Relationship to Patient



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Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of
Patient's Name (please print)

Digestive Health Associates Notice of Privacy Practices.

Signature of Patient

Date



Notice of Privacy Practices

This notice is required by the Federal Privacy Regulations created as a result of the Health Insurance Portability and accountability Act of 1996

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY

Internal Medicine Group, P.C., doing business at Digestive Health Associates of Cheyenne (DHA) is committed to protecting the privacy of your individually identifiable health information. DHA is required to give you this notice to tell you how we use and disclose your protected health information (PHI) and instruct you on your rights relating to this information.

DHA's Use or Disclosure of Your Practiced Health Information (PHI):

- **Treatment:** DHA uses your PHI to treat you. For example, we may ask you to have laboratory test (such as blood or urine), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Finally, we may also disclose your PHI to other physicians who are involved in your treatment
- **Payment:** DHA may use and disclose your PHI in order to bill and collect payment for the services you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.
- **Health Care Operations:** DHA may use and disclose your PHI to operate our business. For example, we may use and disclose your information to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for DHA.
- **Appointment Reminders:** DHA may use and disclose your PHI to contact you and remind you of any appointment
- **Release of Information to family/friends with your Permission:** DHA may release your PHI to a family member or friend involved in your care, or who assist in taking care of you with your permission. For example, a family member who assist you in meeting your health care needs may accompany you on a visit to DHA. The family member may have access to your medical information while we are treating you and/or to assist in your follow up care.
- **Disclosures Required by law:** DHA will use and disclose your PHI when we are required to do by federal, state or local law.

Authorization

DHA may obtain your written authorization to use or disclose your PHI for any purpose that is not set out in this notice. DHA will obtain written authorization from you to use your PHI for marketing or fundraising purposes. You may revoke your authorization at any time.

This is a revised notice for DHA. The effective date of this revised notice is September 23, 2016. DHA may revise this notice from time to time, when this notice is revised, it will be posted at DHA facilities. It will be posted on DHA's website at <http://dhawy.com>

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Your Rights:

You may:

- Inspect and obtain a copy of your PHI held by DHA
- Amend any of your PHI created by DHA if you believe it is incorrect or you believe that information is missing, and DHA agrees. If DHA agrees, we will advise you of that fact. You may have a statement of your disagreement added your PHI.
- Obtain a list of those who have received your protected health information from DHA for any disclosure made after April 14, 2003 not to exceed 6 years.
 - This list will not include certain disclosures such as PHI for:
 - Your treatment
 - Your payment
 - Our healthcare operation
 - Given to and/or authorized by you and your personal representative for DHA to release
 - PHI that was disclosed for law enforcement purposes.
- Ask DHA to communicate with you in a different manner or at a different place such as sending PHI to your office rather than your home address.
- Request that DHA limit how your PHI is used and disclosed. DHA will accommodate reasonable requests but may not agree with limitations that conflict with treatment, payment, or health care operations.
- Request that any service paid in full by you not be included in disclosure to your health plan
- Obtain a paper copy of this notice

You may exercise the foregoing rights by contacting DHA's Privacy officer in writing, at the address listed below

DHA's Responsibilities and Rights:

DHA:

- Is required by law to maintain the privacy of your PHI and to furnish you with your notice of our legal duties and privacy practices regarding PHI
- Must follow the terms of the notice currently in effect
- Must obtain a signed acknowledgement or document that you received this notice
- Will never sell your PHI
- Will notify you in writing of any breach where your PHI was unsecured
- May revise our privacy practice as outlined in this notice and make the new practice effective for all the PHI we maintain. DHA will issue revised notice should our privacy practices be changed.

Complaints:

If you believe your privacy rights may have been violated, you may express concerns or make a complaint with DHA and/or to the Secretary of the Department of Health and Human Services. There will be no retaliation against any person making a complaint. Complaints made to DHA should be made in writing to the attention of the Privacy Officer at DHA at the address set forth below.

If you have questions or concerns or wish to issue a complaint, please contact:

Privacy Officer
Digestive Health Associates of Cheyenne
7212 Commons Circle
Cheyenne, WY 82009

Telephone (307)635-4141

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Notice of Privacy Practices

DHA's Use or Disclosure of Your Protected Health Information(PHI) (Continued):

- **Military and Veterans:** If the individual is a member of the armed forces, DHA may release PHI as required by military command authorities. DHA may also release PHI to the appropriate foreign military authority if the individual is a member of a foreign military.
 - **Workers' Compensation:** DHA may disclose PHI for workers' compensation or similar programs. These programs provide benefits for work--related injuries or illness.
 - **Public Health Risks:** DHA may discuss PHI for public health risks or certain occurrences. These risks and occurrences generally include disclosures to prevent or control disease, injury, disability; report birth and deaths; report child, elder or dependent adult abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure when required or authorized by law).
 - **Health Oversight Activities:** DHA may disclose PHI to a health oversight agency, such as the Department of Health and Human Services or Center for Medicare and Medical Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
 - **Data Breach Notification Purposes:** DHA may use or disclose the individuals PHI to provide legally required notices of unauthorized access to or disclosure of PHI.
 - **Lawsuits and Disputes:** If the individual is involved in a lawsuit or a dispute, DHA may disclose PHI in response to a court or administrative order. DHA also may disclose PHI in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell the individual about the request or to allow the individual to obtain an order protecting the information requested.
 - **Law Enforcement:** DHA may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstance, DHA is unable to obtain the individuals agreement; (4) about a death DHA believes may be the result of criminal conduct; (5) about criminal conduct on DHA's premises; and (6) in an emergency to report a crime or victims, or the identity, description or location of the person who committed the crime.
 - **Coroners, Medical Examiners and Funeral Directors:** DHA may release to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death, DHA also may release PHI to funeral directors as necessary for their duties.
 - **National Security and Intelligence Activities.** DHA may release PHI to authorized federal officials for intelligence, counter--intelligence, and other national security activities authorized by law.
- Inmates or Individuals in Custody: If the individual is an inmate of a correctional institution or under the custody of a law enforcement official, DHA may release PHI to the correctional institution or law enforcement official. This release would be necessary if; (1) for the institution to provide the individual with health care; (2) to protect the individual's health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Authorization

DHA may obtain your written authorization to use or disclose your PHI for any purpose that is not set out in this notice. DHA will obtain written authorization from you to use your PHI for marketing or fundraising purposes. You may revoke your authorization at any time.