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 Information

Today's Date_____

Patient Name_____
First MI Last

Mailing Address_____City_____State_____Zip_____

Telephone Home_____Work_____Cell_____

As a service to our clients, we provide a courtesy appointment reminder call.
By providing your cell phone number, you consent to receiving call at this number.

Social Security _____Date of Birth_____Age_____Gender M / F

Email_____
_

Marital Status:	**Race:**	**Ethnicity:**	**Primary Language:**
___Single ___Married ___Divorced ___Widowed	___American Indian/Alaskan Native ___Black or African American ___Native Hawaiian/Pacific Islander ___Caucasian ___Multiracial ___Other	___Hispanic/Latino ___Non-Hispanic / Non-Latino ___Other	___English ___Spanish ___French ___Other
Primary Caregiver ___Self ___Other: _____	Are you deaf? ___YES ___NO Are you blind? ___YES ___NO	**Advanced Directive?** ___YES ___NO	**Do you need a Translator?** ___YES ___NO

Employer_____Occupation_____Telephone_____

Authorized Parties to Speak with Regarding Billing:_____

Parties Responsible for Payment (if other than the patient):

Name_____ Social Security_____ Date of Birth_____

Mailing Address_____City_____State_____ZIP_____

Telephone Home_____Work_____Cell_____

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Patient Name_____

Date of Birth_____

Insurance Information:
Primary 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:_____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 herby authorized medical treatment of the above named patient and agree to be financially responsible for all charges for such treatment, including cost of collections and legal fees (if applicable). I herby assign payments to Digestive Health Associates. I authorize Digestive Health Associates to release my 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_____

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Review of Systems / Past Medical History

Patient Name_____

Date of Birth_____

Please mark the conditions that apply:

General:		
___Chronic Fatigue	___Bruise Easily	___Fever
___Thyroid Disease	___Anemia	___Less Interest on doing things
___Weight Loss (amount___)	___Cancer_____	
___Weight Gain (amount___)	___Diabetes (diagnosed when_____)	
Eyes, Ears, Nose & Throat:		
___Ringing in Ears	___Sinus Trouble	___Poor Vision
___Ear Infections	___Hoarseness	___Glaucoma
___Dizzy Spells	___Eye Infections	___Cataracts
Lungs:		
___Pneumonia	___Bronchitis	___Shortness of Breath
___Asthma	___Cough	
Heart:		
___Chest Pain	___Palpitations	___Irregular Heart Beat
___High Blood Pressure	___Ankle Swelling	___Blood Clots
Skin:		
___Rashes	___Allergic Reaction/Hives	___Growths
Urinary:		
___Urinary Infections	___Painful Urination	___Blood In Urine
___Kidney Stones	___Urination at Night	___Decrease in Urine Force or Flow
Bones and Joints:		
___Arthritis	___Weak Bones	
___Back Pain	___Swollen Joints	
Neurological/Psychiatric:		
___Stroke	___Depression	___Seizures
___Tremors/Hands Shaking	___Nervousness	___Panic Attacks
___Numbness or Tingling	____Problems Sleeping	___Migraines
___Headaches (frequent)	___Memory Loss	___Anxiety
Gastrointestinal:		
___Diarrhea	___Constipation	___Liver Disease
___Heartburn	___Stomach Pain	___Gas
___Black Stools	___Poor Appetite	___Trouble Swallowing
___Nausea	___Vomiting	___Change In Bowels
___Blood In Stool	____Bloating	

Additional information you feel is important:_____
_____
_____

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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:

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

Other GI Surgical procedures not listed:_____
_____
_____

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

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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):

- ◯ Admission history and physical
- ◯ Discharge Summary
- ◯ Complete hospital chart
- ◯ Lab Reports
- ◯ Psychiatric and other mental health records
- ◯ Medication administration logs, dietary logs, staff contact or service logs, and o other records that may not be part of my individual medical record, but which Contains information relating to me.
- ◯ Outpatient Records
- ◯ Office Notes
- ◯ Consultation notes or reports
- ◯ Radiological Reports

(These records should be redacted to protect information pertaining to other patients)
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 revocation is received.

I also understand:

- I am not required to sign this authorization and That my health care payment will not be affected By my refusal
- Federal privacy regulation will no longer apply
- To the information disclosed, and that DHA 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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Acknowledgement 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**

DIGESTIVE HEALTH ASSOCIATES of Cheyenne

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 as 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 may 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 Protected Health Information (PHI):

- **Treatment:** DHA uses your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), 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 assists you in meeting your health care needs may accompany you on a visit to DHA. This 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 so by federal, state or local law.

Authorization:

DHA will 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, and when this notice is revised, it will be posted at DHA facilities. It will also be available on DHA's website at http://www.dhawy.com

DIGESTIVE HEALTH ASSOCIATES of Cheyenne

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 to 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.
  - The list will not include certain disclosures such as PHI for:
    - Your treatment
    - Your payment
    - Our healthcare operation
    - Given to and/or authorized by you or 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 for in full by you not be included in disclosures 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 your 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 practices as outlined in this notice and make the new practices effective for all the PHI we maintain. DHA will issue a 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.

Contact:

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

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