



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

Social Security _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Cell _____

Which phone would you like to be the primary number we call: _____

Authorize Text-to-Pay: Yes No

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

Email (for patient portal access and communications): _____

Gender Assigned at Birth: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Multiracial <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Other	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Mandarin <input type="checkbox"/> Other
	Primary Caregiver <input type="checkbox"/> Self <input type="checkbox"/> Other: _____	Are you deaf? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you blind? <input type="checkbox"/> Yes <input type="checkbox"/> No	Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need a Translator: <input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Pharmacy: _____

Patient consents to importing medication history: 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? _____

Have you visited our website? Yes or No (circle one) Were you influenced by our website to come here? Yes or No

Referred by: _____

I hereby 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 hereby 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** _____



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"/> Outpatient Records
<input type="radio"/> Discharge Summary	<input type="radio"/> Office Notes
<input type="radio"/> Complete hospital chart	<input type="radio"/> Consultation notes or reports
<input type="radio"/> Lab Reports	<input type="radio"/> Radiological Reports
<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)
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 / Advanced Directives

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

Digestive Health Associates Notice of Privacy Practices and Advanced Directive
Acknowledgement.

Signature of Patient

Date

Witness to Signature

Date



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Advanced Directive Acknowledgement

Federal Law:

The 1990 Patient Self-Determination Act is a federal law that states patient must be informed of their right under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to have an advance directive. The advance directive document is a way for you to communicate what kinds of medical care and treatment you do or do not want if you become unable to make these decisions for yourself.

Wyoming Law:

Under the Wyoming Health Care Decisions Act of 2005, as amended in 2007, Wyoming authorized a combined advance health-care directive. This Law is intended for inpatient hospital admissions, care received from a nursing facility, home health agency, personal care service, hospital, or health maintenance organization and not for clinics.

DHA:

DHA is a clinic and therefore does not fit the above-mentioned categories for intended use and therefore will not honor advance directives. If a life-threatening situation were to happen DHA employees would provide BLS services and notify emergency services for transfer to Cheyenne Regional Medical Center. If a patient needs to be sent to the hospital for any reason and the person has presented DHA with Advance Directive information, that information will be given to the emergency service providers along with any other pertinent health information.

The existence of an Advance Directive, or lack thereof, will not determine the patient's right to care, treatment or services at DHA. Any patient who has questions now or in the future should be directed to their health care provider. Patients who would like to have an advance directive should speak with legal counsel.

Wyoming Endoscopy Center:

Wyoming Endoscopy Center does not honor advance directives. Health care providers at Wyoming Endoscopy Center are bound to do all in their power to assure the safe recovery of every patient, including resuscitation if that becomes necessary. Because the scope of care in this facility is limited to elective outpatient surgical procedures, any life-threatening event will be immediately treated with life sustaining measures and emergency services notified for transfer to Cheyenne Regional Medical Center. If a Patient has provided advanced directives to Wyoming Endoscopy Center, they will be given to emergency services along with any pertinent medical information. All patients are to be informed that an advance directive will not be honored while a patient is at Wyoming Endoscopy Center. The existence of an Advance Directive, or lack thereof, will not determine the patient's right to care, treatment or services at DHA. Any patient who has questions now or in the future should be directed to their health care provider. Patients who would like to have an advance directive should speak with legal counsel.



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.

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 August 5, 2019. 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>



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Your Rights:

You may:

- Provide DHA with a copy of your Advanced Directives
- 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.
 - 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:

- DHA will acknowledge that you have provided DHA with an Advanced Directive, but DHA will not honor it
- DHA does not permit the use of video or voice recording of any kind while on DHA or WEC premises
- 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 Compliance Officer at DHA at the address set forth below.

Contact:

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

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

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