



**ASSOCIATES, P.C.**  
**Raoul Joubran, MD, PC · Kent D. Katz, MD · Phillip T. Krmpotich, MD**  
**and**  
**Casper WY Endoscopy ASC, LLC DBA Sterling Surgical Center**

**\*\*\*IT IS YOUR RESPONSIBILITY TO KEEP YOUR PHONE NUMBER AND ADDRESS INFORMATION UPDATED WITH US\*\*\***

PLEASE PRINT

Legal Name/Preferred Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address/Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*CORRESPONDENCE FROM OUR OFFICE IS MAILED IN A SEALED ENVELOPE*

If other than your home address, please print the address of where you would like your billing statements and/or correspondence to be sent: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we leave confidential messages (appointment reminders, test results, etc.) on your home answering machine or voicemail?  YES  NO

Other than your home phone, where do you want to receive calls about your appointments, lab and x-ray results or other health care information? Phone number: \_\_\_\_\_

May we leave a message?  YES  NO

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

May we leave confidential messages at your place of employment?  YES  NO

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Employer Phone Number \_\_\_\_\_

If the patient is a minor child: Parent/Guardian's name \_\_\_\_\_

Parent/Guardian's Birthdate \_\_\_\_\_ Parent/Guardian's SS# \_\_\_\_\_

Referring doctor \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
and any other doctors you want to receive a copy of your records:

**Information about my general medical condition and diagnosis as well as treatment and payment information may be released to, [list name(s) and phone number(s)]: (example: spouse, siblings, parents)**

**ONLY IN AN EMERGENCY, please notify, [list name(s) and phone number(s)]:**

Person financially responsible \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ Policyholder's Name \_\_\_\_\_

Complete Claim Address & Telephone Number \_\_\_\_\_

Policyholder's date of birth \_\_\_\_\_ Policyholder's SS# \_\_\_\_\_

Patient's relationship to the policyholder \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policyholder's Name \_\_\_\_\_

Complete Claim Address & Telephone Number \_\_\_\_\_

Policyholder's date of birth \_\_\_\_\_ Policyholder's SS# \_\_\_\_\_

Patient's relationship to the policyholder \_\_\_\_\_ Policy/ID # \_\_\_\_\_

**GASTROENTEROLOGY ASSOCIATES, P.C.**

Assignment of Benefits. I hereby assign, transfer and set over to Gastroenterology Associates PC all of my rights, title and interest to my medical reimbursement benefits under the insurance policy I have named above for professional services provided by, Phillip T. Krmpotich MD/Kent D. Katz MD/Raoul Joubran MD in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information I hereby authorize Phillip T. Krmpotich MD/Kent D. Katz MD/Raoul Joubran MD to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

Medicare-Medicaid I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

**Patient Name Printed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient/Parent/Guardian/\*POA Signature** \_\_\_\_\_

(\*POA/Legal Guardian documentation must be included)

**CASPER WY ENDOSCOPY ASC, LLC DBA STERLING SURGICAL CENTER**

Assignment of Benefits. I hereby assign, transfer and set over to Sterling Surgical Center all of my rights, title and interest to my medical reimbursement benefits under the insurance policy I have named above for professional services provided by Phillip T. Krmpotich MD/Kent D. Katz MD/Raoul Joubran MD in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information I hereby authorize Phillip T. Krmpotich MD/Kent D. Katz MD/Raoul Joubran MD to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

Medicare-Medicaid I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

**Patient Name Printed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient/Parent/Guardian/\*POA Signature** \_\_\_\_\_

(\*POA/Legal Guardian documentation must be included)



ASSOCIATES, P.C.

Raoul Joubran, MD, PC · Kent D. Katz, MD · Phillip T. Krmpotich, MD

1441 Wilkins Circle, Casper, WY 82601

ph: (307) 233-2700 · toll free: (800) 380-1820 · fax: (307) 472-2883

---

## PATIENT INTERVIEW FORM

---

### PATIENT INFORMATION

---

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

#### EMAIL

Please check one as your preferred email for communications

Personal: \_\_\_\_\_  Work: \_\_\_\_\_

#### RACE

- White/Caucasian  Native Hawaiian/Other Pacific Islander  
 Black/African American  American Indian/Alaska Native  
 Asian  Unknown  Patient declines to provide information

#### ETHNICITY-Please check one of the following IN ADDITION to the above

- Hispanic or Latino  Not Hispanic or Latino  Patient declines to specify

#### LANGUAGES SPOKEN

Primary language spoken:  English  Spanish  Other \_\_\_\_\_

#### GENDER

- Male  Female  Other

---

### SOCIAL HISTORY

---

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

#### MARITAL STATUS

- Single  Married  Divorced  Separated  Widowed

#### ALCOHOL

Yes  No (none)---If yes, date last used: \_\_\_\_\_

*Consumption* *Number*

- Never  
 Rarely \_\_\_\_\_  
 Daily \_\_\_\_\_  
 2 days or less/week \_\_\_\_\_  
 More than 2 days/week \_\_\_\_\_

#### TOBACCO

*Smoking Status*

- Current every day smoker  Current some day smoker  Former smoker  Never smoker  
 Smoker, current status unknown  Light tobacco smoker  Heavy tobacco smoker  
 Unknown if ever smoked  Vapor/E-Cigarettes

**TOBACCO (continued)**

Type	Started	Quit	Quantity	Frequency
<input type="checkbox"/> Cigarettes	_____	_____	_____	Cigarettes/day
<input type="checkbox"/> Cigar	_____	_____	_____	Cigars/day
<input type="checkbox"/> Chewing Tobacco	_____	_____	_____	Times/day
<input type="checkbox"/> Pipe	_____	_____	_____	Times/day
<input type="checkbox"/> Vapor/E-Cigarettes	_____	_____	_____	Times/day

**DRUG USE** Yes  No (none)

Type	Number
<input type="checkbox"/> I have never used recreational drugs	_____
<input type="checkbox"/> I have used recreational drugs in the past	_____
<input type="checkbox"/> I am currently using recreational drugs	_____
<input type="checkbox"/> I have been treated for substance abuse	_____

**PHARMACY INFORMATION**

Local Pharmacy: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

May we import/obtain your medication history from your pharmacy(s)?:  Yes  No**ALLERGIES** Patient has no known allergies  Patient has no known drug allergiesHave you ever had a reaction to any type of anesthesia?  Yes  No If yes, which type \_\_\_\_\_

Please list allergies (medications and environmental) and your reaction. If additional space is required please provide a list.

\_\_\_\_\_

**CURRENT MEDICATION** None

Please list current medications and dosages including any over the counter medications, i.e. vitamins, herbs, aspirin, pain medication. If additional space is required please provide a list.

\_\_\_\_\_

**DIAGNOSTIC STUDIES/TESTS**

Have you had any of the following? Please check all that apply.

<input type="checkbox"/> None		<input type="checkbox"/> Flex Sig	When: _____
<input type="checkbox"/> EGD	When: _____	<input type="checkbox"/> Colonoscopy	When: _____
<input type="checkbox"/> ERCP	When: _____	<input type="checkbox"/> Liver Biopsy	When: _____

**PAST OR PRESENT MEDICAL CONDITIONS** None

<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart attack/angina
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Prostate cancer	<input type="checkbox"/> Blood clot/DVT/PE	<input type="checkbox"/> CHF
<input type="checkbox"/> Lung cancer	<input type="checkbox"/> Other Cancer _____	<input type="checkbox"/> Bleeding ulcer	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Skin cancer	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Liver cancer	<input type="checkbox"/> Esophageal cancer	<input type="checkbox"/> History of blood transfusions	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gall stones	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Reflux	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Celiac disease

**PAST OR PRESENT MEDICAL CONDITIONS (continued)**

- Liver disease       Hepatitis A       Hepatitis B       Hepatitis C  
 Anxiety disorder     Depression       Obstructive Sleep Apnea     Hypothyroidism  
 High Cholesterol     Bleeding Disorder (specify) \_\_\_\_\_  Other: \_\_\_\_\_

**PREVIOUS PROCEDURES/SURGERIES**

- None  
 Appendectomy       C-Section       Cardiac Bypass       Cardiac Surgery       Hiatal Hernia  
 When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_  
 Colon Resection     Prostate       Joint Replacement     Hysterectomy  
 When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_  
 Cholecystectomy/Gallbladder     Obesity Surgery     Other \_\_\_\_\_  
 When \_\_\_\_\_      When \_\_\_\_\_      When \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

I am adopted and do not know my family history

*Do you have a family history of:*

- Celiac Disease                       Yes  No                      Colon Cancer                       Yes  No  
 Colon Polyps                           Yes  No                      Crohn's Disease                   Yes  No  
 Inflammatory Bowel Disease     Yes  No                      Liver Disease                       Yes  No  
 Ulcerative Colitis                     Yes  No

**FAMILY HEALTH STATUS**

- Mother       Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Father       Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Sister       Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Brother      Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Daughter    Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Son          Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Grandmother  Healthy & Living       Deceased/At Age \_\_\_\_\_  
 Grandfather  Healthy & Living       Deceased/At Age \_\_\_\_\_

Which family member, if any, has been diagnosed with the following:

<i>DIAGNOSIS</i>	<i>RELATIONSHIP</i>
Alcoholism	
Barrett's Esophagus	
Brain Cancer	
Breast Cancer	
Celiac Disease	
Colitis	
Colon Cancer	
Colon Polyps	
Crohn's Disease	
Esophageal Cancer	
Gastric Cancer	
Kidney Cancer	
Liver Cancer	
Liver Disease/Cirrhosis	
Ovarian/Uterine/Endometrial Cancer	
Pancreatic Cancer	
Stomach Cancer	
Tendency of Bleeding	
Ulcer Disease	
Ulcerative Colitis	

**Review Of Systems** Please check any symptoms you are currently experiencing

<p><b>Gastrointestinal</b></p> <p><input type="radio"/> None Y N</p> <p>difficulty swallowing <input type="radio"/> <input type="radio"/></p> <p>change in bowel habits <input type="radio"/> <input type="radio"/></p> <p>heartburn <input type="radio"/> <input type="radio"/></p> <p>indigestion <input type="radio"/> <input type="radio"/></p> <p>abdominal pain <input type="radio"/> <input type="radio"/></p> <p>abdominal swelling <input type="radio"/> <input type="radio"/></p> <p>bloating or fullness after meals <input type="radio"/> <input type="radio"/></p> <p>nausea <input type="radio"/> <input type="radio"/></p> <p>vomiting <input type="radio"/> <input type="radio"/></p> <p>gas <input type="radio"/> <input type="radio"/></p> <p>stomach cramps <input type="radio"/> <input type="radio"/></p> <p>constipation <input type="radio"/> <input type="radio"/></p> <p>diarrhea <input type="radio"/> <input type="radio"/></p> <p>yellowing of skin or eyes (jaundice) <input type="radio"/> <input type="radio"/></p> <p>rectal bleeding <input type="radio"/> <input type="radio"/></p> <p>bright red blood from rectum <input type="radio"/> <input type="radio"/></p> <p>black tarry stools <input type="radio"/> <input type="radio"/></p>	<p><b>Neurological</b></p> <p><input type="radio"/> None Y N</p> <p>dizziness <input type="radio"/> <input type="radio"/></p> <p>fainting <input type="radio"/> <input type="radio"/></p> <p>frequent headaches <input type="radio"/> <input type="radio"/></p> <p>migraine <input type="radio"/> <input type="radio"/></p> <p>numbness or tingling <input type="radio"/> <input type="radio"/></p> <p>seizures <input type="radio"/> <input type="radio"/></p> <p>tremors <input type="radio"/> <input type="radio"/></p>	<p><b>Allergic/Immunologic</b></p> <p><input type="radio"/> None Y N</p> <p>HIV exposure <input type="radio"/> <input type="radio"/></p> <p>allergic to soy or eggs <input type="radio"/> <input type="radio"/></p> <p>allergic to latex <input type="radio"/> <input type="radio"/></p> <p>persistent infections <input type="radio"/> <input type="radio"/></p> <p>strong allergic reactions or chronic hives <input type="radio"/> <input type="radio"/></p>
<p><b>Cardiovascular</b></p> <p><input type="radio"/> None Y N</p> <p>chest pain <input type="radio"/> <input type="radio"/></p> <p>shortness of breath w/exercise <input type="radio"/> <input type="radio"/></p> <p>irregular heart beat <input type="radio"/> <input type="radio"/></p> <p>sleep upright for comfort (orthopnea) <input type="radio"/> <input type="radio"/></p> <p>palpitations <input type="radio"/> <input type="radio"/></p> <p>leg swelling <input type="radio"/> <input type="radio"/></p> <p>frequent fainting <input type="radio"/> <input type="radio"/></p>	<p><b>Hematologic/Lymphatic</b></p> <p><input type="radio"/> None Y N</p> <p>bleeding gums or palpable lymph nodes <input type="radio"/> <input type="radio"/></p> <p>easy bruising <input type="radio"/> <input type="radio"/></p> <p>prolonged bleeding <input type="radio"/> <input type="radio"/></p>	<p><b>Constitutional</b></p> <p><input type="radio"/> None Y N</p> <p>fatigue <input type="radio"/> <input type="radio"/></p> <p>fever <input type="radio"/> <input type="radio"/></p> <p>loss of appetite <input type="radio"/> <input type="radio"/></p> <p>sweats <input type="radio"/> <input type="radio"/></p> <p>weight gain <input type="radio"/> <input type="radio"/></p> <p>weight loss <input type="radio"/> <input type="radio"/></p>
<p><b>Respiratory</b></p> <p><input type="radio"/> None Y N</p> <p>shortness of breath <input type="radio"/> <input type="radio"/></p> <p>cough <input type="radio"/> <input type="radio"/></p> <p>wheezing <input type="radio"/> <input type="radio"/></p> <p>asthma <input type="radio"/> <input type="radio"/></p> <p>excessive sputum <input type="radio"/> <input type="radio"/></p> <p>coughing up blood <input type="radio"/> <input type="radio"/></p> <p>shortness of breath with exercise <input type="radio"/> <input type="radio"/></p> <p>sleep apnea <input type="radio"/> <input type="radio"/></p>	<p><b>Genitourinary</b></p> <p><input type="radio"/> None Y N</p> <p>dark urine <input type="radio"/> <input type="radio"/></p> <p>decrease in urine flow <input type="radio"/> <input type="radio"/></p> <p>pain with urination <input type="radio"/> <input type="radio"/></p> <p>frequent urinary infections <input type="radio"/> <input type="radio"/></p> <p>frequent urination <input type="radio"/> <input type="radio"/></p> <p>blood in urine <input type="radio"/> <input type="radio"/></p> <p>impotence <input type="radio"/> <input type="radio"/></p> <p>urinary frequency at night <input type="radio"/> <input type="radio"/></p>	<p><b>Psychiatric</b></p> <p><input type="radio"/> None Y N</p> <p>anxiety <input type="radio"/> <input type="radio"/></p> <p>depression <input type="radio"/> <input type="radio"/></p> <p>difficulty sleeping <input type="radio"/> <input type="radio"/></p> <p>hallucinations <input type="radio"/> <input type="radio"/></p> <p>nervousness <input type="radio"/> <input type="radio"/></p> <p>panic attacks <input type="radio"/> <input type="radio"/></p> <p>paranoia <input type="radio"/> <input type="radio"/></p>
<p><b>Eyes</b></p> <p><input type="radio"/> None Y N</p> <p>red eyes <input type="radio"/> <input type="radio"/></p> <p>double vision <input type="radio"/> <input type="radio"/></p> <p>loss of vision <input type="radio"/> <input type="radio"/></p> <p>sensitive to light <input type="radio"/> <input type="radio"/></p>	<p><b>Integumentary</b></p> <p><input type="radio"/> None Y N</p> <p>hives <input type="radio"/> <input type="radio"/></p> <p>rashes <input type="radio"/> <input type="radio"/></p> <p>allergies <input type="radio"/> <input type="radio"/></p> <p>dryness <input type="radio"/> <input type="radio"/></p> <p>itching <input type="radio"/> <input type="radio"/></p> <p>yellow skin or eyes <input type="radio"/> <input type="radio"/></p> <p>lesions <input type="radio"/> <input type="radio"/></p>	
<p><b>ENMT</b></p> <p><input type="radio"/> None Y N</p> <p>sore throat <input type="radio"/> <input type="radio"/></p> <p>nose bleeds <input type="radio"/> <input type="radio"/></p> <p>difficulty swallowing <input type="radio"/> <input type="radio"/></p> <p>dizziness <input type="radio"/> <input type="radio"/></p> <p>runny nose <input type="radio"/> <input type="radio"/></p> <p>ear pain <input type="radio"/> <input type="radio"/></p> <p>nasal obstruction <input type="radio"/> <input type="radio"/></p>	<p><b>Endocrine</b></p> <p><input type="radio"/> None Y N</p> <p>excessive thirst <input type="radio"/> <input type="radio"/></p> <p>hair loss <input type="radio"/> <input type="radio"/></p> <p>heat intolerance <input type="radio"/> <input type="radio"/></p>	
	<p><b>Musculoskeletal</b></p> <p><input type="radio"/> None Y N</p> <p>arthritis <input type="radio"/> <input type="radio"/></p> <p>back pain <input type="radio"/> <input type="radio"/></p> <p>gout <input type="radio"/> <input type="radio"/></p> <p>joint deformity <input type="radio"/> <input type="radio"/></p> <p>joint pain <input type="radio"/> <input type="radio"/></p> <p>muscle weakness <input type="radio"/> <input type="radio"/></p> <p>stiffness <input type="radio"/> <input type="radio"/></p>	

**Reviewed with**

Patient
  Parent
  Guardian
  Not Present

**Signature** (please sign below)



ASSOCIATES, P.C.

Raoul Joubran, MD, PC · Kent D. Katz, MD · Phillip T. Krmpotich, MD  
and  
Casper WY Endoscopy ASC, LLC DBA Sterling Surgical Center

## FINANCIAL POLICIES

The professional services provided by this practice are for your benefit. All fees charged by this practice are your responsibility. For your convenience Gastroenterology Associates, P.C. and Sterling Surgical Center accepts Cash, Checks, Money Orders, Visa, MasterCard & Discover Card.

### Insurance

Gastroenterology Associates/Sterling Surgical Center will bill your insurance as a courtesy; however, payment and/or payment arrangements are expected at the time service is rendered. After 60 days from the date of service, the account will be treated as a self-pay account and you will be required to submit payment in full or make acceptable payments. We will pre-authorize all procedures with your insurance company. If for some reason your procedure date is changed, please contact our billing office so we may notify your insurance company of the change whatever the reason. Failure to do so may alter your reimbursement with a denial or loss, making it your financial responsibility. You have authorized the assignment of your insurance benefits to this office for services. Professional care is provided to you, our patient, not to an insurance company. Thus, the insurance company is ultimately responsible to you, the patient, and you are responsible to the doctor. In order for us to file your insurance, we need to be provided with COMPLETE AND ACCURATE insurance information to avoid delays in payment (i.e. name, address, group, etc. of your primary and secondary insurance). Failure to provide us with correct information could possibly result in you being responsible for your account. **You are responsible for all fees not covered by your insurance company including, deductibles, co-pay and reasonable and customary fee differences.** Our office cannot accept responsibility for negotiating a settlement on a disputed claim. If you dispute the amount of payment made by your insurance company, you should contact your insurance carrier, your human resources department or your agent directly.

### Payment

All payment arrangements should be made at the time or before service is rendered. Should it be necessary to make payment arrangements the following guidelines will be used, a minimum payment should be 10% of the original balance or \$50.00 whichever is greater. Should you need assistance in payment of your medical care, please let us know immediately.

The services provided by our physicians are the professional fee. For procedure related services there would be other charges, ie. facility fee, possible pathology charges, anesthesiology or other fees not charged by this practice.

Gastroenterology Associates/Sterling Surgical Center cannot be responsible for your bill with other agencies, i.e. labs, pathology, etc. Any problems with payment of fees other than Gastroenterology Associates/Sterling Surgical Center are the patient's responsibility.

### Unpaid Accounts

Patients with unpaid delinquent accounts or accounts which have been written off to bad debt or collection may be denied treatment if not medically necessary.

### Disclosure Agreement

I have been informed that the physician rendering services to me may have ownership interest in the following facilities: Sterling Surgical Center, Summit Medical Center, Casper Surgical Center, Sheridan Surgical Center, Sweetwater Surgical Center and Center for Surgical Excellence.

Patient/Parent/Guardian/POA Signature

Date

# NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information. Your information may be stored electronically and if so it is subject to electronic disclosure.

## How We Use & Disclose Your Patient Information

**Treatment:** We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

**Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.

**Health Care Operations:** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

## Special Uses and Disclosures

Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

## Others Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

**Required by Law:** We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

**Research:** We may use or disclose information for approved medical research.

**Public Health Activities:** We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

**Health oversight:** We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

**Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena, discovery request or court order.

**Law Enforcement purposes:** We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.

**Deaths:** We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and donation agencies.

**Serious threat to health and safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

**Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

**Business Associates:** We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

**Messages:** We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell you health information, unless you have signed an authorization.

## Individual Rights

You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

You have the right to request that we amend your information.

You may request a list of disclosures of information about you for reasons other than treatment, payment or health care operations and except for other exceptions.

You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

## Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

## Changes in Privacy Practices

We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person(s) listed below.

## Complaints

If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send written complaint to the U.S. Department of Health and Human Services. The person(s) listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

## Contact Person(s)

If you have any questions, requests, or complaints, please contact:

**Gastroenterology Associates, P.C.**  
Laura Renemans, Office Manager

**Casper WY Endoscopy ASC, LLC**  
**DBA Sterling Surgical Center**  
Maryann Gracey, Facility Director

I, \_\_\_\_\_  
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
patient/parent/guardian/POA

If not signed, reason why acknowledgment was not obtained: \_\_\_\_\_

Staff Witness seeking acknowledgment

\_\_\_\_\_ Date: \_\_\_\_\_

Effective Date: 09/01/2013