GASTROENTEROLOGY 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*
☐ Cigarettes				Cigarettes/day
☐ Cigar				Cigars/day
☐ Chewing Tobacco				Times/day
☐ Pipe				Times/day
☐ Vapor/E-Cigarettes				Times/day

DRUG USE

☐ Yes ☐ No (none)

Type	*Number*
☐ I have never used recreational drugs	
☐ I have used recreational drugs in the past	
☐ I am currently using recreational drugs	
☐ 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 allergies

Have 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.

☐ None		☐ Flex Sig	When: _____
☐ EGD	When: _____	☐ Colonoscopy	When: _____
☐ ERCP	When:_____	☐ Liver Biopsy	When: _____

PAST OR PRESENT MEDICAL CONDITIONS

☐ None

☐ Colon polyps	☐ Ovarian cancer	☐Anemia	☐ Heart attack/angina
☐ Colon cancer	☐ Prostate cancer	☐ Blood clot/DVT/PE	☐ CHF
☐ Lung cancer	☐ Other Cancer_____	☐ Bleeding ulcer	☐ Stroke
☐ Breast cancer	☐ Skin cancer	☐ Bleeding disorder	☐ High blood pressure
☐ Liver cancer	☐ Esophageal cancer	☐ History of blood transfusions	☐ Pacemaker/Defibrillator
☐ Kidney Disease	☐Asthma	☐ Chronic Lung Disease	☐ Emphysema
☐ Kidney stones	☐ Gall stones	☐ Diabetes	☐ Pancreatitis
☐ Reflux	☐ Ulcer	☐ Barrett's Esophagus	☐ 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 When_____ ☐ C-Section When_____ ☐ Cardiac Bypass When_____ ☐ Cardiac Surgery When_____ ☐ Hiatal Hernia When_____
☐ Colon Resection When_____ ☐Prostate When_____ ☐ Joint Replacement When_____ ☐ Hysterectomy When_____
☐ Cholecystectomy/Gallbladder When_____ ☐ Obesity Surgery When_____ ☐ Other_____ 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 Polyps ☐ Yes ☐ No
Inflammatory Bowel Disease ☐ Yes ☐ No
Ulcerative Colitis ☐ Yes ☐ No
Colon Cancer ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No
Liver Disease ☐ 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:

DIAGNOSIS	*RELATIONSHIP*
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	

PATIENT INFORMATION –

Please check any symptoms you are currently experiencing:

Review Of Systems

Gastrointestinal

☐ None

	Yes	No
difficulty swallowing	☐	☐
change in bowel habits	☐	☐
heartburn	☐	☐
indigestion	☐	☐
abdominal pain	☐	☐
abdominal swelling	☐	☐
bloating or fulness after meals	☐	☐
nausea	☐	☐
vomiting	☐	☐
gas	☐	☐
stomach cramps	☐	☐
constipation	☐	☐
diarrhea	☐	☐
yellowing of skin or eyes (jaundice)	☐	☐
rectal bleeding	☐	☐
bright red blood from rectum	☐	☐
black tarry stools	☐	☐

Cardiovascular

☐ None

	Yes	No
chest pain	☐	☐
shortness of breath w/exercise	☐	☐
irregular heart beat	☐	☐
sleep upright for comfort (orthopnea)	☐	☐
palpitations	☐	☐
leg swelling	☐	☐
frequent fainting	☐	☐

Respiratory

☐ None

	Yes	No
shortness of breath	☐	☐
cough	☐	☐
wheezing	☐	☐
asthma	☐	☐
excessive sputum	☐	☐
coughing up blood	☐	☐
shortness of breath with exercise	☐	☐
sleep apnea	☐	☐

Eyes

☐ None

	Yes	No
red eyes	☐	☐
double vision	☐	☐
loss of vision	☐	☐
sensitive to light	☐	☐

ENMT

☐ None

	Yes	No
sore throat	☐	☐
nose bleeds	☐	☐
difficulty swallowing	☐	☐
dizziness	☐	☐
runny nose	☐	☐
ear pain	☐	☐
nasal obstruction	☐	☐

Neurological

☐ None

	Yes	No
dizziness	☐	☐
fainting	☐	☐
frequent headaches	☐	☐
migraine	☐	☐
numbness or tingling	☐	☐
seizures	☐	☐
tremors	☐	☐

Hematologic/Lymphatic

☐ None

	Yes	No
bleeding gums or palpable lymph nodes	☐	☐
easy bruising	☐	☐
prolonged bleeding	☐	☐

Genitourinary

☐ None

	Yes	No
dark urine	☐	☐
decrease in urine flow	☐	☐
pain with urination	☐	☐
frequent urinary infections	☐	☐
frequent urination	☐	☐
blood in urine	☐	☐
impotence	☐	☐
urinary frequency at night	☐	☐

Integumentary

☐ None

	Yes	No
hives	☐	☐
rashes	☐	☐
allergies	☐	☐
dryness	☐	☐
itching	☐	☐
yellow skin or eyes	☐	☐
lesions	☐	☐

Endocrine

☐ None

	Yes	No
excessive thirst	☐	☐
hair loss	☐	☐
heat intolerance	☐	☐

Musculoskeletal

☐ None

	Yes	No
arthritis	☐	☐
back pain	☐	☐
gout	☐	☐
joint deformity	☐	☐
joint pain	☐	☐
muscle weakness	☐	☐
stiffness	☐	☐

Allergic/Immunologic

☐ None

	Yes	No
HIV exposure	☐	☐
allergic to soy or eggs	☐	☐
allergic to latex	☐	☐
persistent infections	☐	☐
strong allergic reactions or chronic hives	☐	☐

Constitutional

☐ None

	Yes	No
fatigue	☐	☐
fever	☐	☐
loss of appetite	☐	☐
sweats	☐	☐
weight gain	☐	☐
weight loss	☐	☐

Psychiatric

☐ None

	Yes	No
anxiety	☐	☐
depression	☐	☐
difficulty sleeping	☐	☐
hallucinations	☐	☐
nervousness	☐	☐
panic attacks	☐	☐
paranoia	☐	☐

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature (please sign below)

Patient/Parent/Guardian/POA Signature Date

GASTROENTEROLOGY 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)

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

GASTROENTEROLOGY 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 _____

Gastroenterology Associates, P.C./Sterling Surgical Center

Medication and Allergy List

Name_____ DOB_____

Date of Completion_____

List all medications you are taking including prescriptions, herbs, vitamins, and over the counter drugs, including dosage, how often each is taken and the last date the item was taken.

Medication	Dosage	How often taken	Last dose taken

List all allergies and their reactions

Allergy	Reaction

Advance Directives / Facility Policy

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Wyoming Statutes § 35--22--101--416: In the state of Wyoming, all patients have a right to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity. Advance directives describe two types of documents that allow a person to give instructions about future medical care.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/ or patient's representative or surrogate) prior to the procedure being performed.

Sterling Surgery Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Maryann Gracey Center Director
1441 Wilkins Circle
Casper, WY 82601
(307)473-1399

You may contact the state to report a complaint:

Wyoming Department of Public Health
401 Hathaway Bldg.
Cheyenne WY 82002
P: (307) 777-7656
health.wyo.gov/main/divisionsprograms

Medicare beneficiaries may also file a complaint with the **Medicare Beneficiary Ombudsman**:

www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman

Medicare

www.medicare.gov
or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General

oig.hhs.gov

This facility is accredited by the **Accreditation Association for Ambulatory Health Care** (AAAHC). Complaints or grievances may also be filed through AAAHC:

5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847) 853-6060 or email: info@aaahc.org

Physician Financial Interest and Ownership:

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:

Dr. Krmpotich, Dr. Fahed, Dr. Joubran

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

_____

Signature of Patient or Patient Legal Representative

Date _____

Patient's Rights and Notification of Physician Ownership

STERLING SURGICAL CENTER

1441 WILKINS CIRCLE
CASPER , WY 82601
(307)473-1399

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

AS A PATIENT OF THE **STERLING SURGICAL CENTER**, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF YOUR PROCEDURE.

PATIENT'S BILL OF RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To be informed of their right to change providers if other qualified providers are available.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and to support participation of thecaregiver in decisions affecting medical treatment.

PATIENT'S RESPONSIBILITIES

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- The patient and/or patient representative is responsible for disposition of patient valuables.
- To accept personal financial responsibility for any charges not covered by their insurance.
- To be respectful of all the healthcare professionals and staff, as well as other patients.

If you need an interpreter:

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you, please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

Gastroenterology Associates, P.C.
and
Casper WY Endoscopy ASC, LLC
DBA Sterling Surgical Center
1441 Wilkins Circle • Casper, WY 82601

Pre-Anesthesia Questionnaire

Patient Name:	Procedure Date:	Age:	❑ Male ❑ Female	Height:	Weight:

Procedure: ☐ **EGD** ☐ **COLONOSCOPY**

Medication Allergies:_____

_____

Have you had any recent hospitalizations or operations _____

Please list all the medications you take (include additional sheet if needed):_____

_____

_____

Health History

☐ Yes ☐ No Diabetes; Last Blood Sugar_____
☐ Yes ☐ No Heart problems (rheumatic fever, murmur, chest, pain, heart attack, irregular heartbeat)
☐ Yes ☐ No High blood Pressure
☐ Yes ☐ No History of Stroke
☐ Yes ☐ No Seizures (epilepsy or convulsions)
☐ Yes ☐ No Lung Problems (asthma, chronic cough, pneumonia, shortness of breath)
☐ Yes ☐ No Can you go up 2 flights of stairs?
☐ Yes ☐ No Sleep Apnea
☐ Yes ☐ No Liver Problems (jaundice, hepatitis)
☐ Yes ☐ No Kidney, bladder or prostate problems
☐ Yes ☐ No Blood clots or bleeding disorders
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Muscle disorders (MS or MD)
☐ Yes ☐ No Mental health issues or phobias
☐ Yes ☐ No Are you allergic to soy or eggs?
☐ Yes ☐ No Do you have insomnia?
☐ Yes ☐ No Do you have fibromyalgia?

☐ Yes ☐ No Other medical problems: _____
_____
☐ Yes ☐ No Have you had any illness, cold, cough or fever within the last week?
☐ Yes ☐ No Is there a possibility that you may be pregnant?
☐ Yes ☐ No Have you or a blood relative ever had an adverse reaction to anesthesia?
☐ Yes ☐ No Do you use tobacco?
How many cigarettes per day?_____
☐ Yes ☐ No Do you drink alcohol?
☐ Daily ☐ Weekly ☐ Occasionally
☐ Yes ☐ No Do you use caffeine? How much? _____
☐ Yes ☐ No Do you have a history of substance abuse or addiction?
☐ Yes ☐ No Do you have any of the following:
☐ Dentures: ☐ Upper ☐ Lower ☐ Both
☐ Loose teeth ☐ Chipped or broken teeth
☐ Bridgework ☐ Caps/Crowns in front

FOR PHYSICIAN'S USE ONLY

Airway: _____
ASA: _____ VS:_____
☐ Deep Sedation ☐ Other:_____
☐ Procedure and risks discussed. Questions answered.
☐ Based on my evaluation of the patient, the risks of the planned anesthesia and the procedure, I have found the patient to be an acceptable candidate.
☐ Heart clear ☐ Lungs clear

_____ _____
Physician's Signature Date & Time

Gastroenterology Associates, P.C. & Casper WY Endoscopy ASC, LLC DBA Sterling Surgical Center
1441 Wilkins Circle, Casper, WY 82601

CONSENT FOR ANESTHESIA

I authorize the Anesthesia Provider below to provide anesthesia services as part of my upcoming procedure(s). ☐Matt Wild, CRNA ☐ Daniel Rust CRNA ☐Antonia Turner, CRNA ☐ Other

_____

I understand and agree that the primary method of anesthesia administration will be deep sedation. This option has been discussed with me in terms that I can understand. If in the course of treatment conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it. These may include, but are not limited to: sore throat, reflux, aspiration, hoarseness, swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic or other reactions to the anesthetic agents; memory dysfunction, memory loss or loss of awareness; nausea and vomiting; dental trauma, including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings, and laceration of the gums or lips; awareness of the procedure while under anesthesia or awakening during the procedure, and/or prolonged recovery from anesthesia. There is also rare potential for serious harm, including difficulties breathing, permanent organ damage, stroke, cardiac arrest and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I have been given the opportunity to ask questions about the anesthesia. All my questions have been answered to my satisfaction. I have been given an explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any procedure and anesthetic, and it is impossible for the Anesthesia Provider to inform me of every possible complication. I believe that I have sufficient information to give the informed consent.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____ _____ _____
Patient/Patient Guardian Signature Date Time

Anesthesia Provider Statement
I certify that I have explained to the patient and/or guardian the risks, benefits, and alternatives of the anesthesia plan and have allowed the patient and/or guardian to ask questions.

_____ _____ _____
Anesthesia Provider Signature Date Time