DALE R MYERS MD
SALLY WHITMAN PA-C
Gynecology/Women's Health

PATIENT AUTHORIZATION - DISCLOSURE OF PROTECTED HEALTH INFORMATION

For Test Results I prefer initial call made to: HOME ◯ CELL ◯ WORK ◯

Appointment reminders: TEXT ☐ EMAIL ☐ PHONE CALL ☐ Circle all that you prefer)

☐ Home Phone – ok to leave messages regarding appointments or request call to our office

☐ Cell Phone – ok to leave message with detailed information

☐ Work Phone – ok to leave message with call back number

I HEREBY GIVE MY AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE SPECIFIC INDIVIDUAL(S) LISTED BELOW. PLEAS CHECK ALL THAT APPLY.

☐ I do not want you to speak to anyone (other than my primary care physician, or physician being referred to by this office, if applicable)

☐ It is acceptable for you to speak with only the following individual(s) regarding my condition **(please check all that apply and provide their name(s):**

_____ Spouse: _____

_____ Parents/Guardians: _____

_____ Siblings: _____

_____ Children: _____

_____ Medical Providers: _____

_____ Other: _____

This authorization will expire on _____ (expiration date or defined event).
If no date/defined event indicated, authorization will remain in place until further notice.

It is the patient's responsibility to notify office staff of any changes to this authorization. A copy of this authorization is considered valid.

Patient Name_____ DOB_____

_____ _____
Patient/Responsible Party Signature Date

DALE R MYERS MD

SALLY WHITMAN PA-C

Gynecology/Women's Health

Please read the following

Assignment of Insurance Benefits: I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, Medicaid, Commercial insurance and other health benefits to: DALE R MYERS MD PC. In the event payment is made directly to me for services rendered by providers in this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize office of Dale R Myers MD PC to release all information necessary to secure the payment.

Responsibility for copay / coinsurance / deductible amounts / pre-auths: We bill insurance carriers for you, provided we are given the proper information. Since my agreement is with my insurance company, I understand this office may not routinely research why my insurance carrier has not paid. I agree to be fully responsible for paying my copay, co-insurance and deductible amounts at the time of service. I understand that it is my responsibility to contact my insurance carrier, prior to time of service, for any pre-authorizations. Even though my insurance may be filed, I understand that all bills are payable upon receipt and that I and/or my spouse/legal guardian, not the insurance company, are financially responsible for all charges whether or not paid by said insurance. If this account is assigned to an attorney or collection agency for collection suit, I shall pay all collection costs. This is also the case in small claims court and garnishment of wages. I understand any unpaid balance may accrue interest at the rate of 2% per month of unpaid balance. Failure to pay unpaid balance may result in termination from practice.

SELF-PAY Patients: I agree that in consideration of services to be rendered, I obligate myself to assume financial responsibility and agree to pay in full at time of service unless prior arrangements have been made. A 20% discount will be offered if payment in full made date of service. If this account is assigned to an attorney or collection agency for collection suit, I shall pay all collection costs. This is also the case in small claims court and garnishment of wages.

Accepted forms of Payment: We accept payment by cash, check and Credit Card (American Express, Discover, MasterCard & Visa).
We also accept Care Credit, which cover health services including copays, co-insurance, deductibles and services not covered by insurance. Care Credit offers no or low interest payment plan options with no annual fees. It can be used at any participating Care Credit provider (including dental and veterinary). More information and application details can be found at www.carecredit.com

Acknowledgment of Notice of Privacy Practices: I acknowledge I have read and understand the HIPAA Notice of Privacy Practices.

Medical Records Release: In event a referral is needed to another physician, I also hereby authorize release of medical information (limited to information related to referral).

Missed Appointments:
In fairness to the provider and other patients, we require at least 24 hour notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice if a pattern of frequent last minute reschedules or no-shows occurs.

Medication Download: I give consent to Dale R Myers MD to download my medication history from my pharmacy into my electronic record.

_____ _____

Patient / Legal Guardian Signature Date

DALE R MYERS MD, P.C.

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

With my consent the practice of Dale R Myers, M.D. P.C. may use and disclose my Protected Health Information to carry out my treatment, for obtaining payment, and to conduct its healthcare operations as outlined in the practice's Notice of Privacy Practices Form.

I have the right and responsibility to review the Notice of Privacy Practices Form prior to signing this consent. I am aware that the Notice of Privacy Practices Form may be revised by this office at anytime. Any such revision will be visible posted and made available to me at my request.

I have been advised to carefully review the list of rights that are available to me with respect to how this office will use and disclosed my Protected Health Information as outlined in their privacy policy. These rights include my right to request in writing certain restrictions on how the office uses and discloses my Protected Health Information.

I have the right to revoke this consent at any time. If I wish to do so I must do so in writing. By signing below I am acknowledging that I have read and understand this consent and the office's Notice of Privacy Practices Form. I further acknowledge that the office's Notice of Privacy Practice Form was readily available for me to read and take with me.

Signature of Patient	Signature of Legal Guardian
Print Patient's Name	Date

New Patient Medical History

Dale R. Myers MD

Sally Whitman PA-C

Name:_____ Date of Birth:_____ Date:_____

Reason for Todays Visit:_____

Pharmacy - Local:_____ Mail Order:_____

Primary Care Provider:_____

Drug Allergies	Reaction Type

Last Menstrual Period Date: _____

History of Abnormal: Pap _____no _____yes

Mammogram _____no _____yes

Last PAP Smear: _____

Done at:_____

Last Mammogram:_____

Done at:_____

Last Pregnancy (Date) :_____ Total #____

Colonoscopy (Year/Physician):_____

DEXA Scan (Year/Facility):_____

Current Medications: Attach List if Available – Continue on Back if need more space

Name	Dose	How Often?

DALE R MYERS MD, FACOG
Gynecology/Women's Health
1613 Stampede Ave, Suite A1
Cody, WY 82414
307/587-1155
307/587-1166 (fax)

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian of _____, minor, I hereby give my consent to Dale R Myers MD, and/or such assistants appointed by the doctor, to examine and treat medically as necessary.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date