COOK SAUTTER
FOOT AND ANKLE

GREGORY B. COOK, D.P.M.
TRAVIS L. SAUTTER, D.P.M.

LOGAN MEDICAL CENTER
550 East 1400 North★Suite B★Logan★Utah 84341★Phone 435★752★9011

BOX ELDER COUNTY SPECIALTY CLINIC
990 South Medical Drive★Suite U3★Brigham City★Utah 84302★Phone 435★734★9623

Fax 435★752★7159

DEMOGRAPHICS

Patient Name_____ Minor □ Single □ Married □ Widowed □

DOB_____ SSN_____ Primary Care Physician_____

Mailing Address_____ City_____ State _____ Zip Code _____

Cell Phone_____ Home Phone_____ Other Phone_____

Email Address (required)_____

(*This is used to provide you with a link to your patient portal and to send emails to remind you of appointments. We also occasionally send out newsletters. We do not share this information with others).*

Emergency Contact_____ Phone_____

Primary Insurance_____ ID_____

Policy Holder (or responsible party if policy holder is a minor) _____ DOB_____

Secondary Insurance_____ ID_____

Policy Holder (or responsible party if policy holder is a minor) _____
DOB_____

This is a direct assignment of my/our rights and benefits under this policy: I hereby name COOK AND SAUTTER FOOT AND ANKLE SPECIALISTS (hereafter CFAAS) as my assignee. I instruct my health care plan to pay CFAAS for all rendered professional services. I grant CFAAS limited Power of Attorney to sign my name in order to deposit and negotiate any payment received from my health care benefit plan and apply funds received towards my outstanding balance. I agree to pay within 30 days any remaining balances due on all professional services charges over and above payments from my health care benefit plan, unless objected to by me in writing. I further agree, should the account be turned over to collections, to pay all collection costs, including, but not limited to, 18% interest, attorneys' fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time the account is turned over to a collection agency. I grant my permission to CFAAS or the clinic's assignee(s) to telephone me at home or at my workplace to discuss matters relating to this form. This assignment shall remain in effect until cancelled in writing. I authorize CFAAS my health care benefit plan, the Health Care Financing Administration, and/or their agents to exchange medical billing and collection information. A photocopy or faxed copy of this agreement shall be considered as effective as the original. I hereby give my permission to the office of CFAAS to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition(s). I authorize the release of any medical information necessary to process my insurance claim(s).

Signature of Patient or Legal Guardian Date

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CONSENT TO TREATMENT

I hereby give permission for COOK & SAUTTER FOOT AND ANKLE, to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ ankle condition(s).

I allow the Practice to file claims for insurance benefits to pay for the care I receive. I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs (such as coinsurance, copayments and/or deductibles).
- I must pay for the cost of these services if my insurance denies services as non-covered or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____

Signature of Patient or Legal Guardian

_____

Patient Name

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PATIENT HIPAA CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that **Cook & Sautter, Foot and Ankle** has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revise this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative

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ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT/ CONTACT AND COMMUNICATION

I, the undersigned, authorize the release of any medical or other information necessary for my insurance to process payment of received services. I also request that payment of authorized Medicare, Medicaid, or health insurance benefits are to be made to **COOK & SAUTTER, FOOT AND ANKLE** for services rendered to myself or to the Patient, if acting as the legally authorized representative of the Patient.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all health care services rendered to Patient from **COOK & SAUTTER, FOOT AND ANKLE** including, but not limited to, any amounts not paid by any insurance company or other third-party payor. By signing below, I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information at the time of service and that **COOK & SAUTTER, FOOT AND ANKLE** will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. A agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) on the unpaid balance until paid in full. In the event any amount(s) are referred to a third-party debt collection agency, I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by §12-1-11 of the Utah Code Annotated. I agree to responsibility of any other amount(s) allowed for by law, including but not limited to court costs, reasonable attorney fees, and interest (both pre- and post-judgement). The terms of this paragraph shall apply to amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. Furthermore, the patient or undersigned, if other than the patient, each jointly and severally agree to pay a service charge of $25.00 plus any bank charges in connection with any check or other instrument tendered by the Patient or the undersigned by returned unpaid to **COOK & SAUTTER, FOOT AND ANKLE**.

I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone number) provided to **COOK & SAUTTER, FOOT AND ANKLE** by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by **COOK & SAUTTER, FOOT AND ANKLE** or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages – some or all of which may result in data charges. I also consent to receiving emails under the same terms at any email address provided by me or anyone associated with me or acting on my behalf. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

I have read the above and accept the assignment of benefits, as indicated, financial responsibility, in full, for this account and acknowledgement of contact and communication permissions.

_____

Signature of Patient or Legal Guardian

_____

Patient Name Date

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RELEASE OF INFORMATION CONSENT

OWNERSHIP
I understand that the physician on staff at **Cook & Sautter, Foot and Ankle** providing medical services is in fact the owner of the facility. I understand that I may choose to have my surgery at **Cook & Sautter, Foot and Ankle.**

Release of Information
Cook & Sautter, Foot and Ankle is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results pertinent to the healthcare of the below named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (if the claims are submitted to an insurance company on your behalf) for services rendered by the physician of **Cook & Sautter, Foot and Ankle**. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

Assignment of benefits and My Financial Responsibility
It is the policy of **Cook & Sautter, Foot and Ankle** to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any copay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the rendered services to me. I hereby assign **Cook & Sautter, Foot and Ankle** all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to **Cook & Sautter, Foot and Ankle.** I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to **Cook & Sautter, Foot and Ankle**, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for **Cook & Sautter, Foot and Ankle** any settlement proceed or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to **Cook & Sautter, Foot and Ankle.** This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Spring Creek Surgical Center be turned over to a collection agency, I will be responsible for any additional charges that may be incurred with the collection of my account, such as interest, court costs, reasonable attorney's fees, etc., in addition to a collection fee of up to 33.33% of the principal amount(s) owing as allowed by Utah Code.

Patient Bill of Rights
I have received and understand the Patient Bill of Rights.

Grievance Procedure
All alleged grievances will be fully documented, investigated, and reported to the Administrator of **Cook & Sautter, Foot and Ankle**. Any substantiated allegation will be reported to the State and/or local authority. The grievance documentation will include the process of how the grievance was addressed. The patient will be provided a thorough, written notice of the decision within ten (10) days of receipt of the grievance.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative

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CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. A medication history is important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. OTC (over the counter) drugs, supplements, or herbal remedies that you take may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____

Signature of Patient or Legal Guardian

_____

Patient Name

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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PATIENT HISTORY & PHYSICAL FORM

Name_____ DOB_____ Date_____

Height_____ Weight_____ Shoe Size _____

Primary Care Physician_____ Preferred Pharmacy_____

How did you hear about us? _____

Past Medical History

Diabetes	**Y** □ **N** □	MI	**Y** □ **N** □	Blood Clots	**Y** □ **N** □
Hypertension	**Y** □ **N** □	Arthritis	**Y** □ **N** □	Acute Infections	**Y** □ **N** □
Cancer	**Y** □ **N** □	Gout	**Y** □ **N** □	Autoimmune Disease	**Y** □ **N** □
Stroke	**Y** □ **N** □	Epilepsy	**Y** □ **N** □	Rheumatoid Arthritis	**Y** □ **N** □
Alzheimer's	**Y** □ **N** □	Anemia	**Y** □ **N** □	Asthma	**Y** □ **N** □
Dark Urine	**Y** □ **N** □	Glaucoma	**Y** □ **N** □	Headaches	**Y** □ **N** □
Heart Attack	**Y** □ **N** □	Heart Condition	**Y** □ **N** □	Hepatitis	**Y** □ **N** □
Kidney Disease	**Y** □ **N** □	Liver Disease	**Y** □ **N** □	Lung Disease	**Y** □ **N** □
Lyme's Disease	**Y** □ **N** □	Nerve Disorder	**Y** □ **N** □	Osteoporosis	**Y** □ **N** □
Phlebitis	**Y** □ **N** □	Poor Circulation	**Y** □ **N** □	Psychiatric Disorder	**Y** □ **N** □
Rheumatic Fever	**Y** □ **N** □	Sciatica	**Y** □ **N** □	Stomach Ulcers	**Y** □ **N** □

Thyroid Problem	**Y** □ **N** □	Tuberculosis	**Y** □ **N** □	Unexplained Weight Loss	**Y** □ **N** □

Past Surgical History

Appendectomy	**Y** □ **N** □ **Year:**	Cardiac Stent Placement	**Y** □ **N** □ **Year:**	Hip Replacement	**L** □ **R** □ **Year:**
Cholecystectomy	**Y** □ **N** □ **Year:**	Cardiac Surgery	**Y** □ **N** □ **Year:**	Knee Replacement	**L** □ **R** □ **Year:**
Hysterectomy	**Y** □ **N** □ **Year:**	Back Surgery	**Y** □ **N** □ **Year:**	Foot Surgery	**L** □ **R** □ **Year:**
Pacemaker	**Y** □ **N** □ **Year:**	Tonsillectomy	**Y** □ **N** □ **Year:**	Ankle Surgery	**L** □ **R** □ **Year:**
Other	**_____ Year:**				

Family Medical History (First Degree Blood Relatives)

	Mother		**Father**		**Sister**		**Brother**		**Daughter**		**Son**	
Diabetes Type I/Type II	T I	T II	T I	T II	T I	T II	T I	T II	T I	T II	T I	T II
Rheumatoid Arthritis												
Stroke												
Hypertension												
Heart Disease												
Gout												
Cancer												
Blood Clots												
Foot Problems												

Past Foot and Ankle Medical History

Ankle Fracture	**Y** □ **N** □	Ankle Sprain	**Y** □ **N** □	Arch Pain	**Y** □ **N** □
Athlete's Foot	**Y** □ **N** □	Broken Foot	**Y** □ **N** □	Bunions	**Y** □ **N** □
Corns/Calluses	**Y** □ **N** □	Cramps in Legs/Feet	**Y** □ **N** □	Childhood Foot Problems	**Y** □ **N** □
Flat Feet	**Y** □ **N** □	Fungal Nails	**Y** □ **N** □	Gait Problems	**Y** □ **N** □
Hammer Toes	**Y** □ **N** □	Heel Pain	**Y** □ **N** □	High Arches	**Y** □ **N** □
Ingrown Nails	**Y** □ **N** □	In-toeing	**Y** □ **N** □	Knee Pain	**Y** □ **N** □
Leg/Foot Ulcers	**Y** □ **N** □	Low Back Pain	**Y** □ **N** □	Neuroma	**Y** □ **N** □
Numbness in Feet	**Y** □ **N** □	Toe Walking	**Y** □ **N** □	Warts	**Y** □ **N** □

Social History

Smoker: **Y** □ **N** □ If Yes: □ Occasional □ Frequent
Vaping: **Y** □ **N** □
Marital Status: □ Single □ Married □ Divorced □ Widowed
Employed: **Y** □ **N** □ Occupation:

Current Medications

Medication	**Dose**	**Frequency**

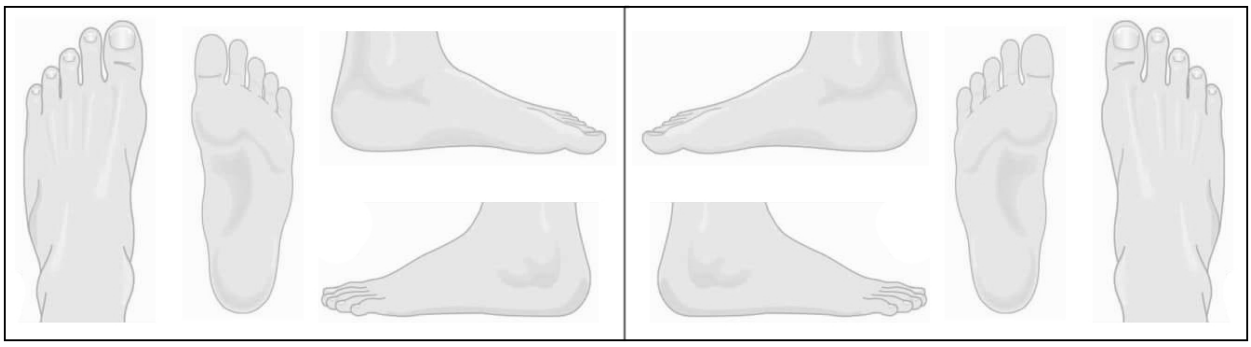
Are you allergic to any medications? **N** □ **Y** □

If yes, please list_____

Are you □ Pregnant or □ Nursing?

Are you slow to heal after cuts?	**Y** □ **N** □		
Any abnormal bruising, bleeding, or scarring?	**Y** □ **N** □		
Do you take supplements that contain any of the following	□ Garlic	□ Ginseng	□ Echinacea
	□ St. John's Wart	□ Gingko Biloba	

History of Present Illness
Please mark the area(s) on this diagram where you are having problems.



What is your reason for being seen today? _____

_____

How long ago did this problem begin? _____

_____

How did the problem begin (work accident/sports injury/began gradually)? _____

_____

Have you been treated for this problem previously? **Y** □ **N** □ If so, where? _____

What treatments have you already tried?

□ Ibuprofen/NSAIDs	□ Orthotic Shoe Inserts	□ Cortisone Injections
□ Rest	□ Ice	□ Elevation
□ Walking Boot	□ Toe Sleeves/Separators	□ Antibiotics
□ Physical Therapy	□ TENS Unit	□ None of the Above
□ Other	□ Surgery: What?	When?

How would you describe your symptoms?

□ Sharp	□ Stabbing	□ Tingling	□ Tearing	□ Burning
□ Dull	□ Stinging	□ Throbbing	□ Hot	□ Crawling
□ Itching	□ Tender	□ Numb		