Cook FOOT & ANKLE

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LOGAN MEDICAL CENTER
550 E 1400 N Suite B Logan, UT 84341 Phone 435-752-9011

BOX ELDER COUNTY SPECIALTY CLINIC
990 S Medical Drive Suite U3 Brigham City, UT 84302 Phone 435-734-9623

Fax 435-752-7159

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and 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 health care operations such as quality assessments and physician certifications.

I have received, or have been offered a copy, read and understand this office's Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices.

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 understand the office is not required to agree to my requested restrictions but that if they do agree then the office is bound to abide by such restrictions.

Patient Name: _____ Date: _____/_____/_____

Signature of Patient or Legal Parent/Guardian: _____

Relationship (if other than patient): _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

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Patient Name: _____ Minor____ Single ____ Married____ Widowed____

DOB: _____ SSN: _____ Primary Care Physician: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work/Other Phone: _____

Email Address (**required**): _____

(This is used to provide you with a link to your patient portal and to send e-mails to remind you of appointments. We also occasionally send 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: _____ DOB: _____

This is a direct assignment of my/our rights and benefits under this policy.

I hereby name Cook 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 toward my outstanding balance. I agree to pay within 30 days any remaining balances due on all professional service charges over and above payments from my health care benefit plan, unless objected to me in writing. I further agree, should the account be turned over to collections, to pay all collections 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 collections 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 Cook Foot and Ankle Specialists 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).

_____ _____/_____/_____

Patient Signature (or Signature of Legal Parent/Guardian if Minor) Date of Signature

Cook FOOT & ANKLE

Patient History & Physical

Patient Name: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Shoe Size: _____ Occupation: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

How did you hear about us? (Please check all that apply.) ☐ Friend/family member ☐ Radio ad ☐ Google
☐ Doctor referral ☐ Cache Valley Family Magazine ☐ Other _____

Medical History:

Have you had, or been treated for:

☐ Ankle fracture	☐ Flat feet	☐ Ingrown nails
☐ Ankle sprain	☐ Fungal nails	☐ In-toeing
☐ Arch pain	☐ Gait problems	☐ Knee pain
☐ Athlete's foot	☐ Hammertoes	☐ Leg/foot ulcers
☐ Broken foot	☐ Heel pain	☐ Low back pain
☐ Bunions	☐ High arches	☐ Neuroma
☐ Corns/calluses		☐ Numbness in feet
☐ Cramps in legs/feet		☐ Toe walking
☐ Childhood foot problems		☐ Warts

Do you currently have, or have you been treated for:

☐ Alzheimer's	☐ Epilepsy	☐ Kidney disease
☐ Anemia	☐ Glaucoma	☐ Liver disease
☐ Anxiety	☐ Gout	☐ Multiple sclerosis
☐ Arthritis	☐ Headaches	☐ Nerve disorder
☐ Asthma	☐ Heart attack	☐ Osteoporosis
☐ Blood clots	☐ Heart condition	☐ Poor circulation
☐ Cancer	☐ Hepatitis	☐ Sciatica
type_____	☐ Hypertension	☐ Stomach ulcers
☐ Depression	☐ Hypothyroidism	☐ Stroke
☐ Diabetes	☐ _____	

Family History:

Have any family members had: (list relationship)

Diabetes: _____ Gout: _____
type I or II? _____ Heart Disease: _____
Cancer: _____ Hypertension: _____
type?: _____ Stroke: _____
Rheumatoid Arthritis: _____

Surgical History:

Please list ALL previous surgeries and dates:

Surgery Done	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Name of Medication	Dose	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Marital status: ☐ Married ☐ Single ☐ Widowed
Are you pregnant? ☐ Yes – Weeks? _____ ☐ No
Do you smoke? ☐ Yes – Packs/day _____ ☐ No
☐ Previous smoker – Quit date _____
Alcohol use: ☐ Yes ☐ N
Recreational drug use? ☐ Yes ☐ No
Caffeine use? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes (list) ☐ No _____

_____

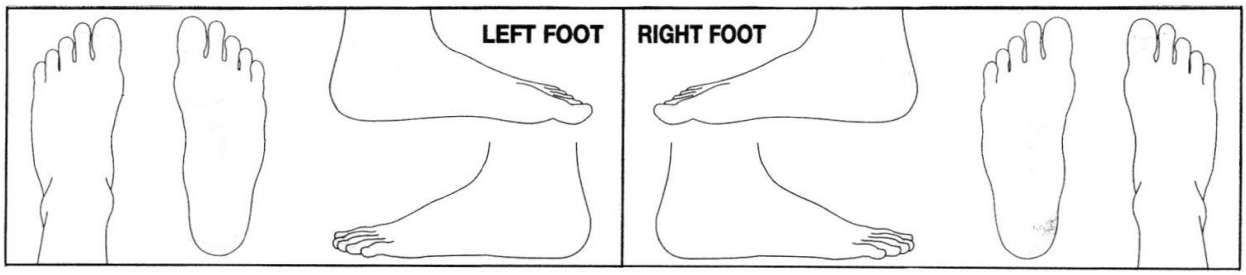
Are you slow to heal after cuts? ☐ Yes ☐ No

Any abnormal bruising, bleeding, or scarring? ☐ Yes ☐ No

Do you take supplements that contain any of the following: ☐ garlic ☐ Gingko biloba ☐ ginseng ☐ Echinacea ☐ St. John's wort

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? _____

Pain level today (1-10)? _____ **Pain occurs:** ☐ **with activity** ☐ **constantly** ☐ **comes and goes**

How long ago did this problem begin? _____

How did the problem begin (i.e. work accident, sports injury, began gradually)? _____

_____

What makes your problem worse (i.e. walking, wearing shoes, etc)? _____

What makes it better (i.e. ice, rest, changing positions, etc)? _____

Have you been treated for this problem previously? ☐ Yes ☐ No If so, where? _____

What treatments have you already tried? ☐ Ibuprofen or other NSAIDs ☐ Orthotics or shoe inserts

☐ Cortisone injections ☐ Rest ☐ Ice ☐ Elevation ☐ Walking boot ☐ Toe sleeves / separators

☐ Surgery (What was done? When?) _____

☐ Antibiotics ☐ Physical therapy ☐ TENS unit ☐ Other _____ ☐ None of the above

How would you describe your symptoms? (Mark all that apply)

☐ Sharp ☐ Stabbing ☐ Tingling ☐ Tearing ☐ Burning ☐ Dull ☐ Numb

☐ Stinging ☐ Throbbing ☐ Hot ☐ Crawling ☐ Itching ☐ Tender