MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of the Lone Peak Foot & Ankle Clinic (the "Clinic") and that the Clinic may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefit companies, or worker's compensation carriers. I further acknowledge that the Clinic may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize the Clinic to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by the Clinic physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with the Clinic's privacy policy.

Patient/Responsible Party Signature:_____ Date:_____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures which the physician may deem advisable in treatment of my case (or as legal guardian for the patient). The Clinic will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature:_____ Date:_____

CREDIT & FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to the Clinic, 74 E Kimballs Ln. Ste 350, Draper, UT 84020. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services, or services deemed as "not medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance of health benefits.
A finance charge (1.5% per month/apr 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $25.00 for each check or other instrument tendered by me but returned to this facility.
Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make co-payments at the time of services.
It is understood and agreed that if I fail to pay this amount in accordance with policy, then I will be responsible for attorney fees and other costs incurred for collection of this amount.
In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient/Responsible Party Signature:_____ Date:_____

MEDICARE PATIENT AGREEMENT

(REQUIRED BY MEDICARE FOR ALL MEDICARE CLAIMS)

Entitlee's Name:_____ Medicare Subscriber Number:_____
I hereby request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. Brockbank for any services furnished me by that provider. I authorize any holder of medical information about me to release to Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it in writing.
Patient/Responsible Party Signature:_____ Date:_____

Greg R Brockbank, DPM, FACFAS / Lone Peak Foot & Ankle Clinic

PATIENT INFORMATION:

Name:_____ **Preferred Name:**_____

Mailing Address:_____**City:**_____**State:**____ **Zip:**_____

Date of Birth:_____ **Age:**_____ **Sex: M F Height:**_____ **Weight:**_____

Phone: ( )_____**(Cell / Home / Work) Phone: ( )**_____**(Cell / Home / Work)**

Email:_____ **Preferred Method of Contact: Text Call Email**

Preferred Language:_____ **Marital Status: Single Married Other:**_____

Ethnicity: Central American Hispanic Non-Hispanic South American Other:_____

Race: African American Asian Caucasian Native American Pacific Islander Other:_____

Social Security Number:_____ **Employer:**_____ **Employer Phone:**_____

Primary Care Physician:_____ **Whom can we thank for referring you to us?**_____

Preferred Pharmacy:_____ **ADDRESS:**_____

RESPONSIBLE PARTY INFORMATION: (If Different From Patient)

Name:_____
Relationship to Patient: (circle one) Spouse Father Mother Other:_____
Mailing Address:_____ **City:**_____**State:**____ **Zip:**_____
Phone: ( )_____ **(Cell / Home / Work) Date of Birth:**_____ **SSN:**_____
Employer:_____**Employer Phone: ( )**_____

PERSON TO CONTACT IN CASE OF EMERGENCY: (Someone With A Different Phone # Than Your Own)

Name:_____ **Phone: ( )**_____ **(Cell / Home / Work)**
Relationship to Patient: (circle one) Spouse Father Mother Other:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____ **ID Number:**_____
Group #:_____ **Relationship to Insured: Spouse Father Mother Other:**_____
Policy Holder's Name:_____ **Policy Holder's Date of Birth:**_____
Claims Address:_____**City:**_____ **State:**____ **Zip:**_____

Secondary Insurance Company:_____ **ID Number:**_____
Group #:_____ **Relationship to Insured: Spouse Father Mother Other:**_____
Policy Holder's Name:_____ **Policy Holder's Date of Birth:**_____
Claims Address:_____**City:**_____ **State:**____ **Zip:**_____

CONTINUE ON BACK FOR SIGNATURES