

MARSHALL L. COOK, M.D.



ARTHROSCOPIC SURGERY
ORTHOPAEDIC SURGERY
SPORTS MEDICINE

Welcome to our practice.

This is a solo, private practice. Dr. Cook's practice focuses on the knee, shoulder and elbow problems, as well as hip arthroscopies.

Marshall L. Cook, M.D. is a Board Certified Orthopaedic Surgeon, Fellowship trained in Sports medicine and Arthroscopic Surgery. He received his Medical Degree at the University of Oklahoma, where he was a Graduate of Distinction, and was inducted into the Alpha Omega Alpha Honor Medical Society. Dr. Cook did his Orthopaedic Residency at the University of Hawaii and his Fellowship in Sports Medicine and Arthroscopic Surgery at the Institute for Bone and Joint Disorders in Phoenix, Arizona, where he also recently served as Director of the Sports Medicine and Arthroscopy Fellowship Academic Program.

Dr. Cook is a nationally recognized designer of orthopaedic instruments, and is a Clinical Assistant Professor of Orthopaedic Surgery at the University of Arizona.

Please deliver any previous x-rays, MRIs, and reports prior to your appointment to allow Dr. Cook to review them, and allow for a more thorough consult.

We look forward to assisting you.

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOWSHIP TRAINED, ARTHROSCOPIC SURGERY AND SPORTS MEDICINE
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

9522 E. SAN SALVADOR DR. STE. 202
SCOTTSDALE, AZ 85258
(480) 767-3951 Fax: (480) 767-3952

MEDICAL HISTORY

Patient Name: _____

Date: _____

DOB: _____

Age: _____

Height: _____

Weight: _____

Medications and Dosages:

Medication Allergies & reaction: _____

Past Medical History

(Aside from the reason that you are seeing us today, have you ever had problems with: (if yes, explain below)

Y	N	Heart	Y	N	High Blood Pressure
Y	N	Lungs	Y	N	Kidneys or Bladder
Y	N	Liver	Y	N	Stomach or Intestines
Y	N	Diabetes	Y	N	Blood Clots
Y	N	Seizures	Y	N	Easy Bleeding
Y	N	Stroke	Y	N	Immune System Deficiency
Y	N	Cancer	Y	N	Arthritis
Y	N	Broken Bones	Y	N	Problem with Anesthesia
Y	N	Other			

Explanation: _____

Y N Do you smoke? How much / day? _____ How long? _____

Past Surgeries: (Procedure and Year) _____

Family History: aside from yourself

Y N Problem with anesthesia _____

Y N Bleeding problems _____

Y N Other medical problems _____

PATIENT REGISTRATION FORM

Patient Name: _____ Date Of Birth: _____
Sex: M / F Marital Status: _____ Relationship To Insured: Self / Spouse / Child
Address: _____ City: _____
State: _____ Zip Code: _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
E-Mail Address: _____ Social Security No: _____
Employer: _____ Phone: (____) _____
Person to notify in case of emergency: _____ Phone: (____) _____

Insured's Name: (if different from patient) _____
Date of Birth: _____ **Social Security No:** _____
Address: (if different) _____
Home phone: () _____ **Cell:** () _____ **Work:** () _____

Is this Work Related: Y / N **Accident Related:** Y / N **Date of Injury:** _____
Is there a claim for injury: Y / N **Name of Attorney:** _____

Primary Insurance: _____ **Phone:** (____) _____
Id # _____ **Group #** _____
Secondary Insurance: _____ **Phone:** (____) _____
Id# _____ **Group #** _____

Referring Physician: _____ **Phone:** (____) _____
Primary Care Physician: _____ **Phone:** (____) _____

In the event it would become necessary to provide a copy of your medical records to another health care provider, including your referring doctor or your primary care doctor, please sign below authorizing the release of your records for this purpose.

Signature: _____ **Date:** _____

I hereby authorize Marshall L. Cook, M.D. to release any information acquired in the course of my examination or treatment as required for processing insurance claims.

I acknowledge that I am responsible for all charges incurred, regardless of possible insurance coverage. I hereby authorize Marshall L. Cook, M.D. to obtain, on my behalf, any insurance information covered by "the privacy act" from my insurance company(s). I hereby authorize payment directly to Marshall L. Cook, M.D.

In the event of default on my account, I acknowledge that i will be responsible for any and all collection fees and/or legal fees as may be required to effect collection of this account.

Signature of Responsible Party **Date**

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CREDIT CARD POLICY

Dear Patient;

You will be asked for a credit card at the time of your check in and the information will be held securely until after your insurance company has processed your claim for that date of service.

Co-pays are due at the time of your visit, as contracted by your insurance company.

After your insurance company processes the claim according to the contractual fee schedule and sends the explanation of benefits (EOB), any remaining balanced owed by you will be charged to the credit card. You will be notified prior to this process and will be sent a receipt upon request.

Although this office is contractually bound by insurance company's fee schedules, you are responsible for any co-insurance amounts, deductibles, non-covered items (such as medical supplies), etc.

In the event you cannot pay the balance in full, payment plans may be set up on an individual basis, if approved, prior to any surgical procedures or placement of medical device (i.e. braces, etc.)

In the event of default of my account, I acknowledge that I will be responsible for collection fees and/or legal fees as may be required to effect collection of this account.

I authorize Marshall L. Cook, M.D. to charge my credit card according to the above terms.

Patient/Guardian Signature

Date

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NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information.

NORMAL USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our practice will use and disclose your health information for the following purposes:

TREATMENT - includes sharing medical data with other providers, making referrals, placing lab and prescription orders, providing appointment reminders or information about treatment alternatives.

PAYMENT – Obtaining payment for treatment.

HEALTH OPERATIONS – quality assurance, utilization review, credentialing, underwriting, and auditing.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information:

1. To public authorities and health oversight agencies that are authorized by law to collection information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of a US or Foreign Military Forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the above address.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Official at the above address. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice.
6. Right to file a complaint. If you believe your privacy has been violated, you may file a complaint with our proactive of the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please mail it to the Privacy Official at the above address. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at the above address.

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PRIVACY POLICY ACKNOWLEDGEMENT

I hereby acknowledge that I have been presented a copy of Marshall L. Cook's Notice of Privacy Practice.

Printed Name of Patient: _____

Patient/Guardian's Signature: _____

Date: _____

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