KAREN A. LANGONE, DPM, FAAPSM, FACFAOM
Board Certified in Podiatric Sports Medicine,
Orthopedics and Medicine
Computerized Gait Analysis

NAME_____DATE OF BIRTH_____

MAILING ADDRESS_____
_____

EMAIL ADDRESS_____

OCCUPATION_____

HOME #_____WORK #_____CELL #_____

How did you hear of our office:_____

Primary Insurance_____**Policy ID**_____

Are you the insured? Yes No Subscriber Name_____

Relationship to insured_____ _____ Insured DOB: _____

Secondary Insurance_____**Policy ID**_____

Are you the insured? Yes No Subscriber Name_____

Relationship to insured_____ Insured DOB: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Dr. Langone all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

_____
Responsible Party Signature Date

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in diagnosis and/or treatment of my feet. I understand that there is a $40 fee if I do not give 24 hour notice for cancellations.

_____
Patient's Signature Date

KAREN A. LANGONE, DPM, FAAPSM, FACFAOM

Primary Care Physician: _____**Referring Physician**: _____
Pharmacy Name, Phone, & Address: _____
Race: _____ *(Example: White, Asian, American Indian, Black or African, Hispanic, etc.)*
Ethnicity: Hispanic/Latino **Not** Hispanic/Latino

Preferred Language: _____ *(Example: English, Spanish, etc.)*

Can this office call the phone numbers on file?	Yes	No	
Can we send mail to the address on file?	Yes	No	
Can we send emails to your email address?	Yes	No	
Who can we leave messages with?	Patient Only	Patient & Spouse	Anyone that answers phone

Allergies *(please write **NONE** if you don't have any allergies)*:
_____
_____

Current Medications *(please write **NONE** if you aren't taking any medications)*:
_____
_____
_____
_____

MEDICAL HISTORY: INDICATE ANY CONDITIONS WHICH YOU HAVE OR HAVE EVER HAD.

Anemia	Alcohol Dependency	Artificial Heart Valve	Artificial Joint	Arthritis
Asthma	Bleeding Disorder	Chemical Dependency	Circulatory Problem	Cancer
Diabetes	Fibromyalgia	Gout	Heart Disease	Heart Murmur
Hepatitis	High Cholesterol	High Blood Pressure	HIV+	Kidney Disease
Liver Disease	Mitral Valve Prolapse	Neurological Problem	Osteoporosis	Other
Pacemaker	Phlebitis	Psychiatric Care	Respiratory Problem	Stroke
Thyroid Problem	Tuberculosis	Ulcers	Varicose Veins	Venereal Disease

NONE OF THE ABOVE:_____

IF YES OR OTHER, PLEASE SPECIFY:_____

_____

LIST ALL SURGERIES/ HOSPITALIZATIONS. If None, Please Write NONE:_____

_____

PRINT NAME_____**SIGN**_____**DATE:**_____

KAREN A. LANGONE, DPM, FAAPSM, FACFAOM

Do you drink? NEVER OCCASIONAL SOCIAL MODERATE HEAVY RECOVERING

Do you exercise? _____ How often? _____ Which activities? _____

Smoking Status: Never Smoker Former Smoker Current Every Day Smoker
Current Some Day Smoker

Blood Pressure: _____ / _____ **Height**: _____ ' _____" **Weight**: _____lbs.

Did you receive an influenza vaccination during the most recent flu season (September – February)?
Yes No

Why are you seeing the doctor today?_____

_____

(Circle all that apply)

Location of the pain: Toe Heel Arch Ball of Foot Ankle Leg Knee Hip Back Left Right Both Central Inside Outside Top Bottom

Nature of the pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing Burning Shooting Numbness

What makes the pain better? Changed Shoes Anti-inflammatory Decreased Activities Icing

When is the pain the worst? In the morning At Night When Active When Resting When Standing

The onset of the pain: Slow Sudden Traumatic

When did the pain start?_____

What have you tried to help the pain?_____

_____

Any previous injuries to your feet, ankles or legs?_____

I understand that I am responsible for notifying the doctor and/or medical staff of any updates to the Information that I provided. I authorize the Doctor's office to retrieve my medication history.
I acknowledge that I received my HIPAA Privacy Practices Notice.

Print Name:_____**Signature**:_____ **Date**: _____

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

HIPPA PRIVACY

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

KAREN A. LANGONE D.P.M.
365 County Road 39A
Suite 9
Southampton, NY 11968

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

HIPPA PRIVACY