Date________________________ Computer No._______________

WELCOME TO OUR OFFICE

Dr./Rev./Mr./Mrs./Ms./Miss.____
Last First M.I.

Date of birth ____________________Age_________________ Sex: ( ) Male ( ) Female

Marital status: ( ) Single ( ) Married ( ) Widowed ( ) Other

Driver's license No.__________________________ Social Security No.___________________________

Address__________________________City____________________State__________Zip____________
Home phone No.____________________________ Cell phone No.______________________________

Occupation_________________________________ Employer__________________________________
Address_________________________ City____________________ State_________ Zip_____________
Phone No. __________________________________

Spouse's name______________________________Employer__________________________________
Work Phone No.____________________________

Primary Care Physician______________________ Date of last visit____________________________

Referred by________________________________

Person Responsible for Payment (if other than above)

Name_____________________________________Relationship_______________________________
Address_________________________City____________________State__________Zip____________
Occupation________________________________ Employer__________________________________
Home phone No.___________________________ Work phone No.______________________________

Person to Contact In Case Of Emergency

Name____________________________________ Relationship_________________________________
Address_________________________City___________________State___________Zip___________
Phone No._________________________________

MEDICAL HISTORY

PLEASE UNDERSTAND THAT THE INFORMATION YOU PROVIDE WILL BE USED IN THE EVALUATION AND TREATMENT OF YOUR PROBLEM, AND THAT IT IS EXTREMELY IMPORTANT TO GIVE COMPLETE AND ACCURATE INFORMATION.

PLEASE BRIEFLY DESCRIBE YOUR FOOT/ANKLE PROBLEM: INCLUDE DURATION AND TREATMENT RENDERED:

Please circle one: Right Left Both

Do you use any of these? ___Walker ___Crutches ___Cane ___Wheel Chair

HAVE X-RAYS BEEN TAKEN OF YOUR FOOT/ANKLE? ( ) YES ( ) NO Date: ____________________

Do you have a copy of the films with you today? ( ) YES ( ) NO

HAVE YOU EVER SEEN A PODIATRIST BEFORE? ( ) Yes ( ) No

Doctor________________________ City___________________ State________Phone______________

Problem____

SYSTEMS REVIEW:

General/Constitutional:

( ) Weight loss
( ) Fever
( ) Frequent colds/flu

Integumentary:

( ) Rash or itching
( ) Changes in hair/nails
( ) Thick scars/keloids
( ) Changes in skin color
( ) Dry skin
( ) Skin ulcers/wounds
( ) Other
Specify____________________
____

Head:

( ) Dizziness/Vertigo
( ) Loss of balance
( ) Head injury/concussion

Neurological:

( ) Seizure Disorder
( ) Numbness/tingling
( ) Paralysis
( ) Headaches
Type____________________
( ) Multiple Sclerosis
( ) Stroke
( ) Other_________________

Eyes:

( ) Blurred vision
( ) Retinopathy
( ) Glaucoma
( ) Cataracts
( ) Macular degeneration

Ears/Nose/Throat:

( ) Ear ache
( ) Poor hearing
( ) Ringing in ears
( ) Nasal polyps
( ) Nose bleeds
( ) Sinus problems
( ) Sore throat

Respiratory:

( ) Asthma
( ) Emphysema
( ) Pneumonia
( ) Tuberculosis
( ) Shortness of breath

Cardiovascular:

( ) Angina
( ) High cholesterol
( ) Irregular heart beat
( ) Heart murmur
( ) High blood pressure
( ) Swelling of feet, ankles Or hands
( ) Heart valve disorder
Type_________________
( ) Other_______________

Peripheral Vascular:

( ) Cold feet
( ) Non- healing sores
( ) Varicose veins
( ) Peripheral Vascular Disease
( ) Phlebitis

Gastrointestinal:

( ) GI Ulcer(s)
( ) Acid reflux
( ) Nausea/vomiting
( ) Hepatitis
Type__________________
( ) Bowel incontinence
( ) Gallstones
( ) Loss of appetite

Genitourinary:

( ) Kidney disease	( ) Frequent urination	( ) Dialysis
( ) Kidney stones	( ) Urinary incontinence	( ) Prostate problems

Musculoskeletal:

( ) Arthritis	( ) Muscle disease	( ) Gout
( ) Joint replacement	( ) Muscle cramps	( ) Myasthenia Gravis
( ) Stiffness or swelling	( ) Hernia	
( ) Joint pain	Type_________________	

Psychiatric:

( ) Anxiety	( ) Insomnia	( ) Alcohol dependence
( ) Depression	( ) Memory loss	( ) Other________________
( ) Panic attacks	( ) Bipolar Disorder	

Endocrine:

( ) Diabetes	( ) Thyroid Disease	( ) Other hormone problem

Hematologic/lymphatic:

( ) Easy Bruising	( ) Anemia
( ) Easy Bleeding	Type_________________

Other:

( ) Cancer	( ) HIV/AIDS/Other STD's
Type_________________	

( ) Other health problem not listed above____
____

( ) I have no known health problems.

SPECIAL NOTE FOR DIABETICS:

Date diagnosed____________________________ Treating physician___________________________

Date last seen by doctor_____________________ Last Hemoglobin A1C________________________

PREVIOUS SURGERIES: (Procedure and date)

____
____
____
____
____
____

( ) I have never had surgery

PREVIOUS HOSPITALIZATIONS: (Other than surgeries listed above)

____
____
____
____
____

( ) I have never been hospitalized

FAMILY HISTORY:

Mother ( )Living ( )Deceased Cause of death________________________________

Father ( )Living ( )Deceased Cause of death________________________________

Brother ( )Living ( )Deceased Cause of death________________________________

Sister ( )Living ( )Deceased Cause of death________________________________

Is there a FAMILY history of any of the following? If yes, please explain relationship:

(Mother/Father/Brother/Sister/Other)

MEDICAL:

( ) Arthritis
( ) Bleeding disorders
( ) Cancer
( ) Circulation problems
( ) Heart disease
( ) High blood pressure
( ) Neurological disorders
( ) Stroke
( ) Diabetes Mellitus

PODIATRIC:

( ) Club foot
( ) Flat feet
( ) Hammertoes
( ) High arched feet
( ) In-toeing
( ) Out-toeing

SOCIAL HISTORY:
Do you smoke? ( )Yes ( )No ______# of packs per day______# of years smoked
Previously smoked? ( )Yes ( )No Quit____
Do you drink? ( )Yes ( )No
( )Light usage, 1-2/week ( )Moderate, 1-2/day ( )Heavy, more than 2 daily

Do you use controlled substances? If yes, explain____

Employment: ( )Sits at job ( )Stands at job ( )Stands and walks at job ( )Retired

Does your employer require any particular type of shoes? ____________________________________

____

CURRENT MEDICATIONS: (prescription and non-prescription)

____
____
____
____
____
____
____

( )I do not take any medication

Pharmacy name and phone number____

ALLERGIES/ADVERSE REACTIONS:
( ) Drug allergies____
( ) Food allergies____
( ) Environmental allergies____
( ) I have no known allergies

____

Have you ever had a local anesthetic (i.e., numbing to have a tooth removed)? ( ) YES ( ) NO

Problems? Please describe____

Height__________________________ Weight______________________________

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.
Payment is expected when services are rendered. We accept most major credit cards, debit cards, cash and checks.
Although our office is in network with many different insurers, please remember that ultimately your insurance policy is a contract between you and your insurance company. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge for services rendered. As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. If a referral is required you MUST have the referral <u>at the time services are rendered,</u> otherwise you will be held financially responsible for such services. As required by law, you will be required to pay co-pays and deductibles at the time of service.

If you have insurance coverage with a plan with which we are not in network, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

Please note that Telehealth services are covered by most insurance companies, with the patient being responsible for co-pays and deductibles. If your insurance company does not cover the cost of these services, you agree to assume full financial responsibility.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

There are several service fees listed below. Please note your insurance company does not cover these fees.

1. $25.00 for filling out disability paperwork. This does not include any doctor's notes we give to you.
2. If you do not give 24 hours' notice when canceling an appointment, or if you do not show for an appointment, you may be charged $75.00.

By signing below, you state that you understand and agree to our office financial policy. You are also authorizing release of any and all information necessary to process your insurance claim, and request payment be made directly to Dr. DiPaolo for any service rendered.

____

Signature of patient/responsible party Date

____

Witness Date

VINCENT DIPAOLO, DPM
NOTICE OF PRIVACY PRACTICES

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 privacy of your medical information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required by law to give you this notice of our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 14, 2003, and will remain in effect until we replace it.

We reserve the right to chance our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information we created or received before we make the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

TREATMENT: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency, that provides care to you. We may disclose information to your immediate family, so that they may assist in your care. We will also disclose protected information to other physicians who may be treating you. For example, your personal health information may be provided to a physician to whom you have been referred to ensure that he has the right information to diagnose or treat you. Your information will also be disclosed to the physician who referred you to our office.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS: We may use, or disclose, as needed, your personal health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other heal related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

USES AND DISCLOSURES BASED ON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

OTHERS INVOLVED IN YOUR HEALTH CARE: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

MARKETING: We may use your protected health information to contact you with information about treatment alternative that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information at the end of this notice.

RESEARCH; DEATH; ORGAN DONATION: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

PUBLIC HEALTH & SAFETY: We may disclose your protected health information to the extent necessary to avert a serious an imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

HEALTH OVERSIGHT: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

ABUSE OR NEGLECT: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be consistent with the requirement of applicable federal and state laws.
FOOD AND DRUG ADMINISTRATION: We may disclose your protected health information to a person or company required by the Food & Drug Administration to report adverse events, product defects or problems, biologic product deviations; to tract products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement to identify or apprehend an individual.
REQUIRED BY LAW: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.
PROCESS AND PROCEEDINGS: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.
LAW ENFORCEMENT: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

PATIENT RIGHTS
ACCESS: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 per page, $25.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us at the end of this notice for a full explanation of our fee structure.
ACCOUNTING OF DISCLOSURES: You have a right to receive a list of the instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past 6 years. We will provide you with the date we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
RESTRICTION REQUESTS: You have the right to request that we place additional restrictions on our use of disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.
CONFIDENTIAL COMMUNICATION: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.
AMENDMENT: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.
If you believe we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
Name of Contact Person: Robbie DiPaolo
Telephone: (806) 293-2525
E-Mail: rdipaolo473@gmail.com
Address: 812 W. 8th Street, Suite 3B, Plainview, Texas 79072

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

I understand that medical information will be disclosed to my immediate family members.

___I do not want immediate family to be given my personal medical information.

In addition to my immediate family members, I also wish to authorize the disclosure of my protected health information to the following individual(s):

Name_________________________ Relationship _____________________Phone____________

Name_________________________ Relationship ___________ _________ Phone____________

I do____/do not____ consent to have messages left on my voicemail, texted to my cell phone, or emailed to me.
Phone number: ____________________________________

E-mail address: ____________________________________

____ ____________________________
Patient Name (please print) Date

____
Signature