



# Galloping Hill ORTHOPEDICS

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**PATIENT INFORMATION SHEET – PLEASE PRINT**

**DATE:** \_\_\_\_\_

Mr/Mrs/Ms/Miss \_\_\_\_\_  
Last Name First Name MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Marital Status: S M D W

**EMAIL:** \_\_\_\_\_ Working Status: \_\_ Working \_\_ Not Working \_\_ Retired \_\_ Disabled

**Pharmacy Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Address** \_\_\_\_\_

\*\*\*\*\*

**GOVERNMENT MANDATED QUESTIONS:**

**Race:** \_\_ White \_\_ Black/African American \_\_ American Indian/Alaska Native

\_\_ Native Hawaiian/Other Pacific Islander \_\_ Other \_\_ Decline to Answer

**Ethnicity:** \_\_ Spanish/Hispanic Origin \_\_ Not of Hispanic Origin \_\_ Patient Declined/Unknown

**Primary Language:** \_\_\_\_\_

**Country:** \_\_\_\_\_

**Secondary Language** \_\_\_\_\_

**Country:** \_\_\_\_\_

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Referring/Primary Physician: \_\_\_\_\_

Name (this must be filled out) AND Address

Phone # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Telephone #: \_\_\_\_\_

Parent/Spouse's Name: \_\_\_\_\_ Parent/Spouse's Date of Birth: \_\_\_\_\_

Parent/Spouse's Employer \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION:** ID# \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

**(PLEASE CIRCLE OR MARK AN "X" FOR ALL ANSWERS LISTED BELOW)**

When did your pain first start? \_\_\_\_\_

How did your pain start? \_\_\_\_\_

Does the pain radiate from this part of your body to another area? No Yes If yes, where? \_\_\_\_\_

What part of the body are you seeing the doctor for today? \_\_\_\_\_

**Was it the result of an accident or injury?** Yes No ( ) car accident ( ) work accident \*( ) other accident

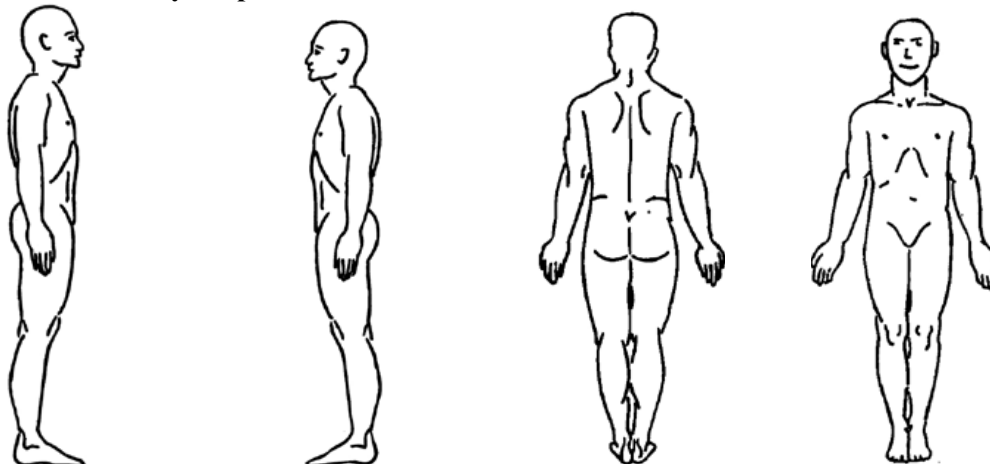
If "other" please explain what type of accident & where it happened \_\_\_\_\_

**Date of Accident/Injury:** \_\_\_\_\_ **Are you involved in litigation (a lawsuit)?** Yes No

**Please circle the words that best describe your pain:**

ACHING HOT SHOOTING SHARP COLD BURNING NUMB SEVERE STABBING TINGLING

**Please indicate where your pain is:**



**On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle your pain scale right now:**

1 2 3 4 5 6 7 8 9 10

**On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle the most pain you have been in over the past two weeks:**

1 2 3 4 5 6 7 8 9 10

**Please circle if your pain is:**

Constant Intermittent Brought on by Aggravating Factors: walking sitting climbing stairs other: \_\_\_\_\_

Is there a time of day when your pain is usually better or worse? Better? AM / PM Worse? AM / PM

**What makes the pain better?** \_\_\_\_\_

**What kind of treatment have you had for pain:** Chiropractor Injections Physical Therapy Surgery Acupuncture

Medication Tens Unit Other \_\_\_\_\_ **How long did you have the treatment?** \_\_\_\_\_

**Do you use an assistive device to get you around:** Cane Walker Wheelchair Scooter

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BLOOD PRESSURE:** \_\_\_\_\_

**Exercise:** \_\_\_ none \_\_\_ rare \_\_\_ regular \_\_\_ occasional **What type?** \_\_\_\_\_

History of substance abuse N Y Smoke N Y Previously smoked N Y Do you live alone N Y

Drink alcohol: \_\_Occasionally \_\_ Rarely Special diet N Y Do you wear dentures N Y

ALLERGIES: Medication Allergies: \_\_\_\_\_

Non Medication Allergies: \_\_\_\_\_

Please check which, if any, apply to you: No known drug allergies \_\_\_ No known other allergies \_\_\_

REVIEW OF SYSTEMS: Do you have problems with any of the following?

Eyes	No	Yes	Bleeding Problems	No	Yes	Blackouts/Fainting	No	Yes
Ears, Nose, Throat	No	Yes	Balance Problems	No	Yes	Psychological Problem	No	Yes
Thyroid	No	Yes	Numbness/Tingling	No	Yes	Bowel Movement	No	Yes
Heart Palpatations	No	Yes	Currently Pregnant	No	Yes	Bladder Problems	No	Yes
Shortness of Breath	No	Yes	Headaches/Dizziness	No	Yes	Chest Pain	No	Yes
Blurred Vision	No	Yes	Hearing Changes	No	Yes	Weakness	No	Yes
Swelling of Ankles	No	Yes	Swelling of other joints	No	Yes	Incontinence	No	Yes
Chronic Cough	No	Yes	Constipation	No	Yes	Sleep Problems	No	Yes

HISTORY PRESENT ILLNESSES: Do you currently have the following conditions?

Arthritis	No	Yes	Epilepsy	No	Yes	Ulcers	No	Yes
Digestion	No	Yes	Cancer	No	Yes	Tuberculosis	No	Yes
Asthma	No	Yes	Hepatitis	No	Yes	COPD	No	Yes
Polio	No	Yes	High Cholesterol	No	Yes	HIV positive	No	Yes
AIDS	No	Yes	Rheumatoid Arthritis	No	Yes	Anxiety/Depression	No	Yes

\*Heart Surgery No Yes \*If yes, did you have a pacemaker or valve replacement \_\_\_\_\_

\*\*Diabetes No Yes \*If diabetic do you take insulin? No Yes

\*\*\*High Blood Pressure No Yes \*\*\*Is your high blood pressure controlled with medication No Yes

Do you have a Family History of cancer, heart disease, diabetes, etc. \_\_\_\_\_

Describe ALL YES Responses: \_\_\_\_\_

What Medications do you take for health problems, pain, including antibiotics, aspirin products and supplements?

Have you had any testing for this condition. If so when was the last date? EKG \_\_\_\_\_ Chest X-ray \_\_\_\_\_

Blood work \_\_\_\_\_ MRI \_\_\_\_\_ Xray \_\_\_\_\_ EMG \_\_\_\_\_ Cat Scan \_\_\_\_\_

Name of hospital/ lab/ doctor's office where tests were performed: \_\_\_\_\_

Have you had any type of Surgery or Hospitalizations: If so what kind of surgery \_\_\_\_\_

Name of hospital \_\_\_\_\_

Have you ever had general anesthesia? N Y Did you have problems? If so please describe :

Date	Reason for Hospitalization	Complications

**PLEASE ANSWER ALL QUESTIONS REGARDING YOUR PRIVACY INFORMATION**

We need this information to comply with federal regulations

**Appointment Information**

**Medical Information**

**On home phone (including auto call)**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**On cell phone (including auto call)**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**On your office Voice Mail**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**With another person**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**Send via Mail**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**Send via Email**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**Send via \*Fax (\*Must be private fax)**

\_\_\_ N \_\_\_ Y

\_\_\_ N \_\_\_ Y

**\*Our office will not be responsible for HIPAA violation of any kind if you have answered YES to any of the above questions**

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s) and phone numbers below:

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE #</u>	<u>CELL PHONE</u>
<hr/>			
<hr/>			
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**ADDITIONAL HIPAA CONTACT INSTRUCTION:**

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\_\_\_\_\_  
\*PATIENT SIGNATURE

\_\_\_\_\_  
DATE SIGNED

**\*BY AFFIXING MY SIGNATURE, I HAVE READ AND UNDERSTAND THE HIPAA QUESTIONS & ANSWERS ABOVE. I ALSO CONFIRM THAT MY ANSWERS TO THE PREVIOUS HEALTH QUESTIONS ARE CORRECT; AND, THAT I HAVE NOT ELIMINATED ANY INFORMATION FROM THE PROVIDERS OF THIS PRACTICE.**



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## ASSIGNMENT OF BENEFITS

**PATIENT NAME:** \_\_\_\_\_

I irrevocably assign payment to Galloping Hill Orthopedics from any and all insurances that I have for services rendered to me. I also waive any and all rights and benefits that were put into place by my insurance carrier as applies to payment benefits. I am aware that ultimately I am responsible for payment of services rendered to me that is not covered by my insurance plan (to include denials to this Practice due to my failure to obtain a referral or if I am remiss in answering any questionnaire sent to me by my insurance carrier). This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

-I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY GALLOPING HIL ORTHOPEDICS TO BE RELEASED TO GALLOPING HIL ORTHOPEDICS.

-I IRREVOCABLY AUTHORIZE GALLOPING HIL ORTHOPEDICS TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME.

-I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO GALLOPING HIL ORTHOPEDICS.

-I IRREVOCABLY AUTHORIZE GALLOPING HIL ORTHOPEDICS TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## COORDINATION OF BENEFIT FORM

Dear Patient – Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company or health care provider.

**Patient ID#** \_\_\_\_\_ **Group Name & #** \_\_\_\_\_

**Patient's name** \_\_\_\_\_ **Subscriber's name** \_\_\_\_\_

**Full name of spouse** \_\_\_\_\_ **Spouse SS#** \_\_\_\_\_

**Spouse's employer:** \_\_\_\_\_ **Spouse DOB:** \_\_\_\_\_

**Is your spouse covered by any health insurance? Y N** **Name of carrier** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Is your problem covered by any other insurance Y N** **Name of carrier** \_\_\_\_\_ **ID#** \_\_\_\_\_

**To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate they do**

**not apply. My signature authorizes insurance carrier, any & all information concerning claims filed by me or on my behalf to another insurance carrier.**

**\*Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*Please note that if your insurance contract contains a pre-existing health clause, they may not pay for the services performed by our office. If payment for services is denied by the insurance carrier, you will be responsible for payment. If our claim is held up for payment by your carrier for investigation of a pre-existing condition for longer than 90 days, you will be responsible for payment of the entire bill. By your signature, you have read our protocol for pre-existing condition clauses.**

**PATIENT LIABILITY AGREEMENT**

**I understand that I am financially responsible for all bills incurred while under the care of Associated Orthopaedics. In the event that my account is not paid in full, I shall be liable for any and all costs of collections, including, but not limited to an additional 35% fee\* (\*as defined by the balance of the bill due divided by .65) of the outstanding balance if my account is forwarded to a collection agency for collection; and, if my account is forwarded to any attorney for legal proceedings. I agree to be liable for an additional attorney fee of 50% of the outstanding balance. I also understand that I need to give the Providers of this Practice at least 24 hours notice if I can't make my office appointment. If I fail to do this, I will be responsible to pay \$50 for the office visit, \$100 for an EMG appointment. I also am being notified that if I do not give at least 48hrs notice for cancelling a surgical procedure, I will be responsible to pay a fee of \$300.00. By signing below, I hereby indicate that I have read this agreement, understand the terms of this agreement and agree to the terms of this agreement.**

**Patient/Guardian (Print Clearly)**

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**Patient/Guardian Signature**

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**Date Signed** \_\_\_\_\_

# Gallopig Hill Orthopedics

Robin Innella, D.O.

Christine Swingle, P.A.

Diplomates, American Osteopathic Board of Osteopathic Surgery

Practice Limited to Orthopedic, Traumatic, Reconstructive Surgery and Sports Medicine

1000 Gallopig Hill rd., Suite 109

Union, NJ 07083

P: 908-964-6600

F: 908-364-1025

670 Broadway

Bayonne, NJ 07002

P: 908-964-6600

F: 908-364-1025

## **MEDICAL APPOINTMENTS CANCELLATION/NO SHOW POLICY**

Thank you for trusting your medical care to Gallopig Hill Orthopedics. When you schedule an appointment with Gallopig Hill Orthopedics we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/ No Show Policy below:

- Effective August 24, 2018 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **24 hour notice** will be considered a **No Show** and charged a **\$50.00 fee**.
- If a **third** no show or cancellation/reschedule with no 24 hour notice should occur, the patient may be **dismissed** from Gallopig Hill Orthopedics.
- The fee is charged to the patient, not to the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments, If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Gallopig Hill Orthopedics 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or weekend, you may leave a message. Messages left are acceptable.

**GALLOPING HILL ORTHOPEDICS    TEL: 908-964-6600    Press 1**

**I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.**

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Signature (Patient/Legal Guardian) Relationship to Patient

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Printed Name

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Date