GALLOWAY ORTHOPEDICS

Patient Name: _____ **Date:** ____/____/____

DOB: ____/____/____ **Height:** ____ Ft. ____ In. **Weight:** _____ Lbs. **Sex: M / F**

Past Medical History *(Circle/Check all that apply)* □ **NO PRIOR / CURRENT MEDICAL ISSUES**

□ Anemia
□ Anxiety / ADHD
□ Asthma
□ Atrial Fibrillation
□ Low / High *(circle one)* Blood Pressure (HTN)
□ Blood Clot (DVT / PE)
□ COVID / Influenza Virus
□ COPD / Emphysema
□ Congestive Heart Failure
□ Diabetes Mellitus (DM) Type 1 / 2 *(circle one)*
□ Epilepsy / Seizures
□ GI Disease
□ Gout / Psoriasis
□ Heart Attack (MI)
□ Heart Disease
□ HIV / AIDS
□ Hypo- / Hyper- *(circle one above)* -thyroidism
□ Kidney / Adrenal Disease
□ Lung / Pulmonary Disease
□ Neuropathy / Nervous Disease
□ Osteoarthritis (OA)
□ Stroke / TIA
□ Vascular Disease
□ Hepatitis -Type: ___
□ Hx of Infection: _____
□ Cancer: _____
□ Other: _____

Are you currently being seen/treated for any other medical condition? No / Yes: _____ ***Treatment:*** _____ ***Duration:*** ____

Surgical History *(Operations/Injections. INCLUDE **Side** & by who)* □ **NO PRIOR SURGICAL HISTORY**

Surgery	Date	Surgery	Date

Social History (Soc Hx)

Tobacco (T) *Yes* / No / Former* Alcohol (A) *Yes* / No / Socially* Recreational Drug Use *(RD) Yes* / No*

**please note amount / frequency*: (T*):_____ (A*):_____ (RD*):_____-Type:_____

Retired: *Yes / No* – Occupation: _____ Eat Healthy Meals: *Yes / No / Often*

Exercise: □ Sedentary (No exercise) □ Mild exercise (walking, golf) □ Regular vigorous exercise (3x+/week)

Family Medical History (FHx)

Mother: □ Alive □ Deceased, Age at Death ____

□ Arthritis
□ Bleeding Dis.
□ Diabetes 1 / 2 (circle one)
□ Heart Attack
□ Heart Disease
□ Hypertension
□ Osteoporosis
□ Stroke
□ Cancers _____
□ Other _____

Father: □ Alive □ Deceased, Age at Death ____

□ Arthritis
□ Bleeding Dis.
□ Diabetes 1 / 2 (circle one)
□ Heart Attack
□ Heart Disease
□ Hypertension
□ Osteoporosis
□ Stroke
□ Cancers _____
□ Other _____

Pharmacy (Name/Address): _____ (Ph. #): (____) _____-_____

Medications *(Check→)* □ **No Current Medications** | □ **SEE LIST (*Below/Attached*)**

(List all prescriptions first, over-the-counter, supplements, vitamins. INCLUDE dose.)

Medication	Dose	Medication	Dose

Allergies *(Check→)* □ **No Known Drug Allergies (NKDA)** | □ **SEE LIST (*Below/Attached*)**

Latex Allergy: Yes / No **Sulfa Allergy: Yes / No** **Penicillin Allergy: Yes/ No**

(List all allergies to medications, associated reactions, and severity)

Allergen	Reaction	Allergen	Reaction

GALLOWAY ORTHOPEDICS

Patient Name: _____ **Date:** ____/____/_____

Who referred you to *Galloway Orthopedics*? _____
Is this a second opinion? *No / Yes, I was seen by:* _____

Location of symptom(s)/pain (main reason for visit): (i.e. low back pain or right shoulder pain)
Rt / Lt / Bilateral _____
Severity: *minor, moderate, severe* — ***Rate your pain: Low- 1 2 3 4 5 6 7 8 9 10 -High***

How long have you had this problem? #_____ □ Days □ Weeks □ Months/Years
Date of Onset/Injury (When did this approximately occur)? ____/____/_____

How did it start? □ Gradually over time □ Suddenly/Accident/Fall □ Auto/MVA □ At Work
□ When Playing Sports/Exercising □ Lifting □ Twisting □ Bending □ Pulling □ Reaching

Briefly describe how the injury occurred (mechanism of injury)?

_____

_____

_____

What have you done to treat it / Which treatments have you tried?
□ Injection(s) (Cortisone/Steroid/HA/Gel) □ Surgery □ Brace/Sleeves □ Weight Loss □ Chiropractor
□ Occupational/Physical Therapy □ Activity Modifications □ Other: _____
□ Seen Other Medical Provider(s): _____

What medications have you taken for this problem? _____
What makes it better / Alleviating symptoms?
□ Rest / Ice / Compression / Elevation (RICE) □ Heat □ Walker/Cane/Crutch(es) □ Other:_____
How long did the above treatment(s) provide relief of pain? #____ □ Min/Hours □ Days □ Weeks □ Months/Yrs

Describe your symptoms or pain. (Circle any that apply)

Quality Of Pain: Stiffness, Sharp, Dull, Aching, Stabbing, Throbbing, Other: _____

Duration: Intermittent, Constant; Morning, Night, Gradually Throughout The Day/All Day

Timing: When Exercising, Working, Driving, Walking, Standing, Sitting, Sleeping, Other: _____

Context; Since You Noticed The Pain It Has Been: Worsening / Improving, Staying The Same, Reoccurring

Associated Symptoms: Bruising, Weakness, Swelling, Instability/Giving Way, Locking/Catching, Tingling, Numbness, Spasms, Radiating Pain, Loss Of Function / Range Of Motion (Rom)

What makes symptoms/pain worse?
□ Bending □ Squatting □ Lifting/Use □ Kneeling □ Exercise/Use □ Climbing Stairs
□ Twisting □ Lying in bed □ Other: _____

Have you had imaging done of the affected area? ☐ X-Ray ☐ CT ☐ MRI ☐ EMG/NCS ☐ NONE
Facility Name: _____ Date: ____/____/_____ **Disk Copy?** Y / N

How did you find us? _____

NEW PATIENT REGISTRATION
Please fill out to the best of your ability

Today's Date ____/____/____

First Name_____ Last Name_____ Middle_____

Social Security # _____ Date of Birth_____ Sex ___ Male ___Female

Mailing Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

Email_____

Phone: Home_____ Cell_____ Work_____

Primary Care Dr._____ Referring Dr. _____

PARENT, SPOUSE, ATTORNEY OR RESPONSIBLE PARTY (if different from patient)

First Name _____ Last Name _____ Middle _____

Address: _____
Street City State Zip

Phone: _____ Date of Birth: _____/____/_____ Social Security#: _____

PRIMARY INSURANCE ____Health Insurance ____ Auto ____ Workers Compensation

Date of Injury or Accident: _____

Insurance Company Name: _____ Address: _____

Name of Policy Holder (Insured): _____ Date of Birth: _____/_____/_____

Policy # _____ Group# _____ Policy Type: ____ HMO ____PPO

Employer: _____ Adjuster Name: _____ Adjuster Phone# _____

Relationship to patient: ____ Spouse ____ Parent (___Mother ___ Father) _____ Partner ____Other

SECONDARY INSURANCE

Insurance Company Name: _____ Address: _____

Name of Policy Holder (Insured): _____ Date of Birth: _____/_____/_____

Policy # _____ Group # _____ Policy Type: ____ HMO ____PPO

Relationship to patient: ____ Spouse ____ Parent (___Mother ___ Father) _____ Partner ____Other

Galloway Orthopedics LLC

Patient Name: _____ Todays Date ____/____/_____

Pharmacy of Choice: _____ Phone #: _____ Address: _____

In Case of Emergency, Who should Be Notified? _____

Relationship: _____ Phone: _____

You may name an individual with whom we may discuss your medical care including treatment, appointments and billing. By naming such person you are authorizing us to release verbal information

Name: _____ Phone: _____ Relationship: _____

Insurance Authorization and Assignment Consent to Treat

I authorize Galloway Orthopedics, LLC to furnish information concerning this illness/accident to insurance carriers and/or audit/compliance agencies. I hereby assign Galloway Orthopedics, LLC all payments for medical services rendered to dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. I also request and consent to treatment and services reasonable and proper by today's standards provided by a physician or provider of Galloway Orthopedics, LLC and any employee acting under my physicians' orders.

Patient or Responsible Party Signature: _____ Date: ____/____/_____

Acknowledgement of Galloway Orthopedics, LLC Notice of Privacy Practices Authorization to Release Information

- I authorize Galloway Orthopedics, LLC through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

- I authorize Galloway Orthopedics, LLC to release to appropriate agencies, any information acquitted in the course of my or the above named patient's examination and treatment.

- I agree that telephone messages regarding my: (Check all that apply)

___ Appointments

___ Prescription Renewals

___ Other Personal Health Information

May be left for me on my ___ Home, ___ Mobile, and/or ___work voice mail system(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL POLICY

Thank you for choosing Galloway Orthopedics, LLC as your healthcare provider. We are committed to making your treatment here a success. Along with providing you with quality service Galloway Orthopedics would also like to assist you with your billing needs.

Any change in home address, phone number, insurance information, or a change of primary doctor must be given to us prior to your appointment. Charges incurred if this information is not given will be patient responsibility.

Our billing office will make every effort to maximize your insurance reimbursement and expedite payment of your claim. Please read the insurance categories below and initial the insurance category that pertains to you.

_____ 1. SELF PAY: Payment is due at the time services are rendered, unless prior arrangements have been made. We accept cash and credit cards.

_____ 2. MEDICARE ONLY: As a participating provider, we will bill Medicare for you. However, you will still be responsible for the 20% that Medicare does not cover. Not all services are covered by Medicare

_____3. HMO PLANS: Galloway Orthopedics will file to your insurance company. All co-pays must be satisfied each and every visit. You are responsible for making sure proper referral information and authorization has been obtained from your primary care physician in advance of your appointment

_____4. MEDICARE WITH SUPPLEMENTAL INSURANCES: Galloway Orthopedics will file to your secondary insurance. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days

_____5. PPO AND COMMERCIAL PLANS: Galloway Orthopedics will file to your insurance carrier. All co-pays, co-insurance, and deductibles will be your responsibility.

_____6. WORKERS COMPENSATION: Galloway Orthopedics will file to your Workers Compensation carrier

_____7. AUTO: Galloway Orthopedics will file to your auto insurance. If benefits are exhausted you will be responsible for the services rendered

PAYMENT POLICY:

In order to establish optimal relations with our patient and avoid misunderstanding and confusion regarding our payment policies, our billing office is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered including applicable co-payments and deductibles. We accept payment in the form of cash, check or credit card. Our office will file claims with the appropriate insurance company. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event your account must be turned over to collections, a collection fee will be added to your account.

I have read this Financial Policy and understand the billing procedures of Galloway Orthopedics. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

Patient or Responsible Party Signature: _____ Date: ____/____/_____

GALLOWAY ORTHOPEDICS

MEDICAL INFORMATION RELEASE FORM

Name_____ Date of Birth___/___/___

Release of Information

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse (Name)_____ Verified by staff_____(initial)
( ) Child(ren)(Name)_____ Verified by staff_____(initial)
( ) Other (Name and relationship_____ Verified by staff_____(initial)

( ) Information is not to be released to anyone.

PLEASE PLACE YOUR INITIALS BESIDE THE OPTIONS BELOW TO AUTHORIZE THE RELEASE OF SENSITIVE INFORMATION PERTAINING TO:
Mental Health _____ Drugs or Alcohol _____ Genetic Testing _____

HIV/AIDS/other infectious diseases _____ Not Applicable: none of these apply to me_____

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call: ( ) my home _____ ( ) my work _____
( )my cell_____ ( ) other_____

If unable to reach me:
( ) you may leave a detailed message.
( ) please leave a message asking me to return your call.
( )_____

Signed: _____ Date:_____/_____/_____

Witness: _____ Date:_____/_____/_____

GALLOWAY ORTHOPEDICS

X-RAY CONSENT FORM (C-ARM)

During my examination, the provider may feel that x-rays will be needed in order to provide diagnoses that can be determined by radiographic imaging and treatment including fluoroscopic-guided injections for precision and accuracy. The type of x-ray device I would be receiving images from is a portable C-arm that is ergonomically and FDA-cleared. I understand this specific device is designed to transmit a low radiation profile exposure that promotes safety for patients, providers, and staff in which a lead-lined room is not required. I understand the risks and potential consequences, if I refuse to provide consent for the proposed treatment as described above. In terms of my insurance coverage, I understand my insurance will be billed for radiographic services rendered. Insurance does not pay for everything, even some care that you or your healthcare provider deems medically necessary. *I also understand that I will be financially responsible for this diagnostic study if the claim is denied or not covered for any reason. It will be my responsibility to appeal such denial if given the option from my insurance company. Even if an authorization is obtained, it is not a guarantee of payment.*

THIS IS TO CERTIFY THAT THE ABOVE INFORMATION HAS BEEN READ IN FULL AND MY SIGNATURE BELOW INDICATES EDUCATION, UNDERSTANDING, AND CONSENT TO SERVICES DESCRIBED ABOVE AT ANY POINT DURING MY APPOINTMENTS.

Patient or Guardian Name (please print):

_____

Patient or Guardian Signature:

_____

Date: _____

GALLOWAY ORTHOPEDICS

We reserve time for each patient in our practice. Please arrive promptly for all scheduled appointments. Lateness of more than 15 minutes might necessitate a rescheduling of your appointment. All cancellations and rescheduling appointments require 2 business days notice. Should you cancel an appointment with less than 2 business days notice, it will constitute a broken appointment and a $50 fee will be assessed. A no show for an appointment will have a $100 fee assessed. We adhere strictly to this policy.

All copays are due and payable at the time of service, so please be aware of your insurance benefits. Should your account become delinquent and turned over to a collection agency, you will be responsible for the balance and all legal and collection fees.

We gladly accept cash, personal checks, and all major credit cards for payment. In the event you have a check returned, the return fee is $50.00. The original check amount plus the $50.00 fee are due in the form of a cash payment only. All future appointments will then be cash or credit card only.

Thank you!

_____

Patient Name

_____ _____

Patient signature Date

3953 Tampa Road Suite 101
Oldsmar, FL 34677
727-464-2867