PREPARING FOR YOUR UPCOMING APPOINTMENT

Please complete the registration form, the medical history form, and the consent form prior to your arrival at our office. The forms are fillable which will allow you to type in the information prior to printing the pages. You will need to print the forms and bring them to your appointment along with the following:

- Current Photo ID
- Current insurance card (s) – the actual card is needed for scanning into our EHR system
- Insurance co-payment, and/or deductible if required by your insurance plan (See "Understanding your medical financial obligation" on the next page)
- Insurance referral from your PCP if required by your insurance plan

You should arrive 15 minutes prior to your scheduled appointment time to allow for our office to process your registration.

The office address is 1777 Hamburg Turnpike, Suite 305, Wayne, NJ 07470

Gary J. Drillings, MD, PA

ORTHOPEDIC SURGERY AND SPORTS MEDICINE

Understanding Your Medical Financial Obligation
How Deductibles, Co-payments, & Coinsurance Work

Health insurance is a contract between you and your insurance company. You pay a premium to your insurance company and in return the insurance company agrees to pay part of your medical expenses. You are generally required to pay the portion of your medical expenses that your insurance company does not pay. Your portion is called cost sharing and includes deductibles, coinsurance, co-payments and exclusions. Understanding how cost sharing works will help you know when and how much you have to pay for your medical care.

Insurance Premium

The health insurance premium is the fee that you pay in order to have coverage of the medical conditions and/or treatments described in the policy. Premiums are established through an underwriting process in which potential purchasers of health insurance are grouped into specific risk categories based upon such factors as age, gender, and medical history.

Deductibles

A deductible is the amount you pay for health care services before your health insurance begins to pay. Health insurance usually requires that the policyholder bears a portion of the risk by paying initial medical costs up to an agreed-upon level (i.e., the deductible) before the health insurance pays for anything. It's like car insurance. Should you need to, you pay your deductible and then insurance kicks in to help pay after the deductible amount is met.

Deductibles can be applied to individuals or to family groups. For example, a policy might have a $3,000 individual deductible and a $5,000 family deductible. In this case, the insurance company would pay the individual's medical claims when the accumulated expenses for that individual **exceed** $3,000 or when the total family expense **exceeds** $5,000, even though the total of no individual's claims equal $3,000.

Patients with a HSA (health savings account) as part of their plan usually have a high deductible plan. The funding mechanism associated with your HSA (debit card, check) should be brought with you to every physician visit.

Co-payments (Co-pay)

In addition to the deductible, policyholders are usually required to pay a portion of the cost of each medical treatment covered. A co-pay is a fixed amount you pay for a health care service. The amount can vary by the type of service. For example, a primary care doctor's office visit might have a co-pay of $30. The co-pay for a specialist or emergency room visit will usually cost more.

Coinsurance

For some services, you may have both a co-pay and coinsurance. Coinsurance is the amount of money that an individual is required to pay for services, after a deductible and co-pays have been paid. Coinsurance is often specified by a percentage such as an 80/20 plan. This means your insurance company will pay 80% of covered services after your deductible has been met and you are responsible to pay the remaining 20%. But you won't have to pay that 20% forever. You pay until you reach your out-of-pocket maximum.

Exclusions

Health insurance policies do not normally cover all medical expenses. The non-covered expense may be defined by medical condition, type of treatment, or medical provider. For example, most health insurers do not cover elective cosmetic surgery such as face lifts. Waterproof casting material is not covered by insurance. Policyholders remain 100% liable for any excluded treatment or expense, and these expenses do not apply to the deductible amount defined in the policy.

What do I have to pay today?

This office will submit covered charges to your insurance company. However, if your plan requires a co-pay for specialist's office visits, we will collect the co-pay at check-in. If you have not met your deductible for specialist office visit, x-rays, injections and devices, we will collect your insurance company's contracted rate for services at check out. Fees for services not covered by health insurance such as waterproof casting material will also be collected at check out.

If your plan requires a referral from your primary care physician, you must provide that document to this office PRIOR to being seen by the doctor. If you fail to provide the document, you will be responsible for all of the office visit charges.

Your plan may or may not have co-pays, deductibles, and coinsurance. If you have questions about what your specific plan covers, you should contact your insurance company directly. Additional information regarding health insurance can also be found at www.healthcare.gov.

PLEASE PRINT OR TYPE

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #

STREET ADDRESS/ P.O. BOX	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	BEST CONTACT # Home Work Cell	SEX ☐ M ☐ F

DATE OF BIRTH	EMAIL ADDRESS	RELATIONSHIP TO RESPONSIBLE PARTY ☐ Self Spouse Parent Child Other

PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER	NAME OF CUSTODIAL PARENT FOR MINOR

The following three questions are requested to comply with federal meaningful use guidelines. Information about these guidelines is available at http://healthit.hhs.gov.

RACE	ETHNICITY	PRIMARY LANGUAGE SPOKEN
White **American Indian or Other Pasific Island** **Black or African American** **Asian** **Unknown** **Other** **Decline Response**	**Latino/Hispanic** **Non-Hispanic** **Unknown** **Decline Response**	

GUARANTOR/RESPONSIBLE PARTY: (If different from patient or insurance/policy holder information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/ P.O. BOX	CITY	STATE	ZIP

EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP TO PATIENT

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards with this form)

PRIMARY POLICY HOLDER'S NAME	SEX M F	POLICY HOLDER BIRTHDATE	
PRIMARY INSURANCE COMPANY NAME		CO-PAY AMOUNT	DOES YOUR POLICY REQUIRE A REFERRAL YES NO
RELATIONSHIP TO PATIENT Self Spouse Parent Child Other		MEMBER ID #	

SECONDARY INSURANCE if applicable:

SECONDARY POLICY HOLDER'S NAME	SEX M F	POLICY HOLDER BIRTHDATE	
SECONDARY INSURANCE COMPANY NAME		CO-PAY AMOUNT	DOES YOUR POLICY REQUIRE A REFERRAL YES NO
RELATIONSHIP TO PATIENT Self Spouse Parent Child Other		MEMBER ID #	

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL

DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I, the undersigned, give my authorization to treat and assign directly to Gary Drillings, MD, PA, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all balances, including copayments, deductibles and coinsurance. Copayments are due at the time of visit. Office charges are due at time of service if your insurance plan requires a deductible be met prior to copayments. Furthermore, I hereby authorize the doctor and staff at this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature, or photocopy of it, on all my insurance submissions.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient representative ____________________ Print name of patient or patient representative ____________________ Date ____________

Gary J. Drillings, MD, PA
ORTHOPEDIC SURGERY AND SPORTS MEDICINE

PATIENT'S NAME	WEIGHT	HEIGHT
PHARMACY NAME & ADDRESS		

Referred By: ______________________ **Date of Injury/Onset of Symptoms:** ____________

Reason for Today's Visit/Chief Complaint: ____

**** Have you had diagnostic tests related to the condition? If yes, please give reports, CDs, films to the receptionist**

Medicare Patients: Primary Physician & Address: ____

PAST MEDICAL HISTORY (check all that apply): ☐ **No Significant Medical History to Report**

Asthma	Breast Cancer	Diabetes	Heart Disease	Hypertension	Hypercholesterol
Hypothyroid	Kidney Disease	Prostate Cancer	Rheumatoid Arthritis	Seizures	Stroke
Other:					

PAST SURGICAL HISTORY (check all that apply, write left /right if applicable): ☐ **No History of Surgery to Report**

Appendix	C-Section	Gallbladder	Heart Bypass	Heart Valve	Hernia
Mastectomy	Prostatectomy	Tonsillectomy	Hip Replacement	Knee Replacement	Spine Surgery
Other:					

MEDICATIONS - Complete all three colums. List additional medications with dosage & frequency on reverse side:

DRUG	DOSAGE	FREQUENCY

MEDICATION OR LATEX ALLERGIES (check all that apply): **No Medication or Latex Allergies**

Penicillin	Sulfa	Aspirin	Codeine	Latex	Other:

SOCIAL & FAMILY HISTORY *** Write in occupation if employed checked**

Work Status: Disabled	Retired	Unemployed	Student	Homemaker	Employed	______________
Marital Status:	Single	Married	Separated	Divorced	Widowed	
Do You Smoke?	Yes	No	If yes, how many packs per day? _______	For how many years? _______		
Do You Drink Alcohol?	Yes	No	If yes, how often? Occasionally	Moderately	Heavy	

	Living	Deceased	Medical Illnesses
Mother			
Father			

Gary J. Drillings, MD, PA
ORTHOPEDIC SURGERY AND SPORTS MEDICINE

ASSIGNMENT, RELEASE & PATIENT'S FINANCIAL RESPONSIBILITIES

CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT, HEALTHCARE OPERATIONS & FINANCIAL POLICY

I understand that as part of my treatment, Gary Drillings, MD, PA, originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
- A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
- A source of information for applying diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed and accurate and actual.
- As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
- A means by which an insurance appeal at any stage, may be filed.
- You are responsible to supply our staff with any and all insurance identification card(s) at the time of your appointment. If your insurance carrier requires a referral from your primary doctor, it is you're responsibility to present this to our receptionist prior to your visit, as we cannot bill your insurance company without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full at the time of visit. All copaysments are due at the time of visit. Office charges are due at time of service if your insurance plan requires your deducible be met prior to copayments.
- Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without a patient payment is subject to immediate collection process. Charges related to collection status, including collection fees, finance charges & legals fees are the responsilbity of the patient or legal representative.
- A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.
- I assign all benefits for my medical services to Gary Drillings, MD, PA.

I understand Gary Drillings, MD, PA will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this concent.

- I authorize Gary Drillings, MD, PA or his staff to discuss and/or release my medical records to the following **friend** or **family member**:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

______________________ Print Patient's Name

______________________ Today's Date

______________________ Signature (Patient or Legal Representative)

______________________ Print Name & Relationship if Signature is Legal Representative