



BEACON

Orthopaedics & Sports Medicine

Physicians

David B. Argo, M.D.
John E. Bartsch, M.D.
John J. Brannan, M.D.
Robert R. Burger, M.D.
Peter S. Cha, M.D.
Haleem Chaudhary, M.D.
Jaideep Chunduri, M.D.
Mohab Foad, M.D.
O. Daniel Fox, M.D.
Timothy Kremchek, M.D.
Glen McClung, M.D.
Ian P. Rodway, M.D.
Robert H. Rolf, M.D.
Henry A. Stiene, M.D.
Angel Velazquez, M.D.

Summit Woods

500 E-Business Way
Suite A
Sharonville, Ohio 45241
Clinic
Tel (513) 354-3700
Fax (513) 354-3705
Imaging
Tel (513) 354-3787
Fax (513) 354-3789
Physical Therapy
Tel (513) 389-3666
Fax (513) 389-3665
Surgery Center
Tel (513) 354-3737
Fax (513) 354-3707

Beacon West

6480 Harrison Ave
Cincinnati, Ohio 45247
Clinic
Tel (513) 354-3700
Fax (513) 354-7601
Imaging
Tel (513) 354-7787
Fax (513) 354-7788
Physical Therapy
Tel (513) 354-7777
Fax (513) 354-7778
Surgery Center
Tel (513) 354-7737
Fax (513) 354-7738

Beacon East

463 Ohio Pike- Suite 201
Cincinnati, OH 45255
Tel (513) 354-3700

Batesville Indiana

1360 East State Rt. 46
Batesville, Indiana 47006
Tel (888) 770-6426
Fax (513) 354-7601

Patient Accounts

Clinic
P.O. Box 634143
Cincinnati, Ohio 45263
Tel (888) 923-7028
Fax (330) 497-7940

Surgery Center
P.O. Box 634137
Cincinnati, Ohio 45263
Tel (513) 354-7700
Fax (513) 354-7701

Dear Patient,

Welcome to Beacon Orthopaedics and Sports Medicine. Your appointment is confirmed for _____ at _____ am/pm with Dr. _____.

Please complete the enclosed registration and history forms. Please bring the completed forms with you to your appointment. If you have had any x-rays taken or other testing done prior to your visit, please bring those as well.

We also require a picture ID and insurance cards at the time of your appointment. If your insurance carrier requires a referral, please contact your primary care physician immediately. We need to receive the referral authorization prior to your visit.

If this is a work related injury, we will require the following information:

- Employer's name, phone number, and contact person
- First Report of Injury
- Name and address of MCO
- Claim Number
- Date of Injury

Please refer to the highlighted address of this letter for the location of your office visit.

We look forward to serving you.

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David Argo, M.D.

Patient Name: _____ Today's Date _____ Age: _____ Date of Birth: _____ Female Male

Dominant Hand R L Height: _____ Weight: _____ Occupation: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Who requested that you visit this office? Doctor Name: _____ Self Referral Attorney

Would you like to receive information by email? N Y Email Address _____

Are you : Single Married Divorced Widowed

1. *(Chief Complaint) Main reason for visit? Pain Numbness Weakness Other

(If other please explain)

2. *(Location) What body part is involved? (Check Below)

<input type="checkbox"/> Neck & radiates to	<input type="checkbox"/> R Arm <input type="checkbox"/> L Arm	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back & radiates to	<input type="checkbox"/> R Leg <input type="checkbox"/> L Leg	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

3. *(Duration) How long has this problem been present? _____ Days Weeks Months Years

4. *Check the ONE box below that best describes how your problem started? Use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

NO INJURY Onset was: Gradual Sudden COMMENTS:

Why do you think it started? _____

INJURY (From accident or sport NOT work or auto related)

Date: _____ Where & how did it happen? _____

What sport? _____

School: _____

INJURY AT WORK From a: Lift Twist Bend Pull Reach

Date: _____

Date: _____ How did your job cause this injury? _____

AUTO ACCIDENT

Date: _____ How was the car hit? _____

Please checkout the box in each category that best describes your problem:

5. *On a scale of 1-10 please rate your pain (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

6. *Quality of pain? Sharp Dull Stabbing Throbbing Aching Burning

7. *Timing of pain? Constant Comes & Goes (intermittent) Does the pain wake you from sleep? Y N

8. *Do you have? Swelling Bruising Numbness Tingling Weakness Loss of bowel/bladder

9. *Since my problem started, it is: Getting Better Getting Worse Unchanged

10. *What makes the symptoms worse? Standing Walking Lifting Exercise Twisting

Lying in bed Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

11. *What makes it better? Rest Heat Ice Elevation Other _____

12. *What medications have you taken for this problem? _____

13. *Which treatments have you tried? _____

14. *Were you seen in the Emergency Room for this problem? N Y Which ER and Date? _____

15. *What tests have you had? X-Rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV)

16. *Have you already had surgery for this problem? N Y Surgeons Name _____ Date: _____

17. *Did you have any adverse reactions to the anesthesia? N Y

18. *Do you have any MEDICAL PROBLEMS? N Y (Please list or check below)

- | | | | | |
|-------------------------------------|--|--|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatoid Arthritis |

Cancer: _____ Other: _____

19.* Do you have any ALLERGIES? N Y Please List _____

20.* Did you bring any X-Rays or Discs with you today? N Y

21.* Did a physician place you off work? N Y

22.* Are you pregnant? N Y

23.* Who is your medical Doctor? _____

24.* Please list any previous surgeries including year _____

25.* Do you use tobacco? N Y Former How Frequently? _____ per day _____ per week

26.* Do you consume alcohol? N Y How Frequently? _____ per day

27.* Do you consume caffeine? N Y How Frequently? _____ per day _____ per week

28.* Do you have a history of recreational drug use? N Y

29.* Describe your activity level Above average Average Sedentary

30.* How frequently do you exercise? 2-3 times/week 3-4 times/week 5 times/week Daily Never

31.* What is your occupation? _____

32.* Do you have any hobbies? _____

REVIEW OF SYMPTOMS

Have you ever had a prior problem with the same Orthopaedic condition you are here for today?

Do you have OTHER JOINTS with Morning Stiffness, Swelling, or Pain?

Please check any that apply to YOU or mark NONE

Heart Burn Nausea Vomiting Loss of Appetite Stomach pain with anti-inflammatory pills

Excessive Thirst Heat/Cold intolerance Trouble Swallowing Fever Weight Loss Hoarseness

Blood in Stool Easy Bleeding Easy Bruising Anemia Painful Urination Blood in Urine

Blurred Vision Double Vision Vision Loss Headaches Dizziness Hearing Loss

Chronic Cough Shortness of Breath Rash Skin Ulcers Lumps Psoriasis

Chest Pain Palpitations Drug/Alcohol Addiction Depression Sleep Disorder

Please list any other medical conditions we should be aware of? _____

Please check any that apply to YOU OR your IMMEDIATE family (Mother, Father or Siblings) & please specify as to which member of your family is afflicted

AIDS/ HIV _____ COPD _____ Depression _____ Hepatitis _____

Alcoholism _____ Colon Cancer _____ Diabetes _____ Kidney Disease _____

Alzheimers _____ Lung Cancer _____ Drug Abuse _____ Osteoarthritis _____

Anemia _____ Breast Cancer _____ Gout _____ Seizures _____

Asthma _____ Prostate Cancer _____ Heart Disease _____ Ulcers _____

Blood Clots _____ Cancer (type) _____ Hypertension _____ Osteopenia or Osteoporosis _____

List any others _____

For Office Use Only

Reviewed by Dr. David Argo _____ Date: _____

**BEACON ORTHOPAEDICS & SPORTS MEDICINE, LTD.
BEACON ORTHOPAEDICS SURGERY CENTER, LLC**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient/Authority Signature: _____ Date: _____

Description of authority: _____

(If the patient is a minor child or otherwise unable to sign this authorization, then obtain the signature of the authorized individual.)

Designation of a Personal Representative

A patient **may** designate a personal representative in writing. A personal representative may be a spouse, adult child, or other members of the patient's family. A personal representative also may be a close personal friend or any individual with power of attorney or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. A parent or legal guardian of a minor (generally a child under the age of 18) will be recognized as a personal representative of the child.

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient. Such information could include: appointment changes, messages regarding surgery and/or testing, physician's responses to phone messages and medication requests.

PLEASE NOTE: an answering machine cannot be used as an acceptable way of leaving information.

A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.

Persons to whom my information may be disclosed:

Name	Relationship	Phone Number
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Patient/Authority Signature: _____ Date: _____

You may revoke or terminate this authorization at any time by submitting a written revocation to Beacon Orthopaedics & Sports Medicine, Ltd./Beacon Orthopaedics Surgery Center, LLC.

45 CFR 164.502 (g) (1) 45 CFR 164.502 (g) (2) (3) and (4)

Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy
Effective April 2009

Patient name: _____ Account #: _____
Please Print

Beacon Orthopaedics and Sports Medicine, LLC (BOSM), believes that in the interest of good health care practices, it is best to establish a patient financial/credit policy between our patients and ourselves in order to avoid any misunderstandings. Our Account Representatives will be glad to discuss your account with you at any time and set up payment plans. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. We expect you to show us the same consideration as you do to your other creditors, and to be honest and forthright regarding your financial responsibility.

(PLEASE INITIAL THE FOLLOWING)

____ 1.) We expect that all co-pays, co-insurance and deductible be paid in full at each visit and prior to surgery, diagnostic testing and physical therapy. We accept cash, check, Debit Card, MasterCard, VISA and Care Credit

____ 2.) We file claims to your insurance company for your primary and secondary policies. You must bring your insurance card with you to every visit and make us aware of any changes in coverage. We also require a copy of your driver's license to confirm identity. Please remember insurance coverage is a contract between the patient and the insurance company. When BOSM files for benefit for services performed, benefits are assigned to BOSM. BOSM will look to the patient for payment in full if insurance does not cover the services provided. If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared to pay this amount.

____ 3.) ***We do not file any insurance with your Automobile Insurance Company, or any other third party (business insurance company, employer, attorney, separated spouses, etc) for purposes of obtaining payment.*** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e., claim form, statement of report). Please speak with our billing representative. We do not accept Letters of Guarantee or other promises to pay when cases settle. You will be extended credit only if arrangements are made in advance and only within our standard guidelines for credit.

____ 4.) If the patient is under age 18, a parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any remaining balances, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility. All minors will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment.

____ 5.) A service charge of \$20.00 will be applied to all returned checks. You will be asked to bring cash, money order or cashier's check to our office to cover the amount of the check plus the service charge. If you present two (2) checks that are returned to us, we will require cash for future services.

____ 6.) If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance.

By signing this agreement, you are acknowledging that you understand our financial/credit policy and agree to pay for all services that are received.

Patient/Guardian Signature: _____ Date: _____

**Driving Directions to Beacon West
6480 Harrison Ave
Cincinnati, Ohio 45247
513-354-3700**

From Northern Cincinnati

Travel South I-75
Take 275 West to I-74 East to the Rybolt Exit
Turn left at the exit
Turn right onto Harrison Ave
Go up the hill and stay in the left lane
You will pass Kohls and Meijers
Turn left at 6480 Harrison Avenue
Proceed up the hill past Huff Building to Beacon Orthopaedics

From West Harrison and Indiana

Take I-74 east to Rybolt Exit
Turn left at the exit
Turn right onto Harrison Ave
Go up the hill and stay in the left lane
You will pass Kohls and Meijers
Turn left at 6480 Harrison Ave
Proceed up the hill past the Huff Building to Beacon Orthopaedics

From Northern Kentucky

Travel I-75 North to I-74 West
Take Exit #11 Harrison/Rybolt Exit
Turn left onto Harrison Ave
You will pass Kohls and Meijers
Turn left at 6480 Harrison Ave
Proceed up the hill past the Huff Building to Beacon Orthopaedics

From Harrison Avenue, South

Take Harrison Ave North from Race Road for approximately 2+ miles
Turn right at 6480 Harrison Ave
Proceed up the hill past the Huff Building to Beacon Orthopaedics

Directions to the Batesville Indiana Office 1360 E. State Road 46 Batesville, IN 47006

From Cincinnati:

- Take I-74 West, into Indiana
- Take Exit 149, Batesville/Oldenburg
- Turn left on IN 229, .2 miles
- Turn left on IN 46, travel 1.5 miles, Junction 129
- Turn left at the light, office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

From Lawrenceburg:

- Take US 48 west to IN 129 N to Batesville. At the junction with IN 46 go straight through the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

From Greensburg/Indianapolis:

- Take I-74 E to exit 149, Batesville/Oldenburg
- Turn right on IN 229 For .2 miles
- Turn left on IN 46, Travel 1.5 miles to Junction with 129
- Turn left at the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

