



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.

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 E. Kremchek, M.D.
Glen McClung, M.D.
Ian P. Rodway, M.D.
Robert Rolf, M.D.
Henry A. Stiene, M.D.
Angel Velazquez, M.D.

Beacon Orthopaedics and Sports Medicine Health Questionnaire

Name _____ Date _____

DOB _____ Age _____ Weight _____ Height _____

Gender: Male ___ Female ___ Race: _____ Ethnicity: _____ Preferred Language: _____

Name of Family Doctor _____

How were you referred to this office?

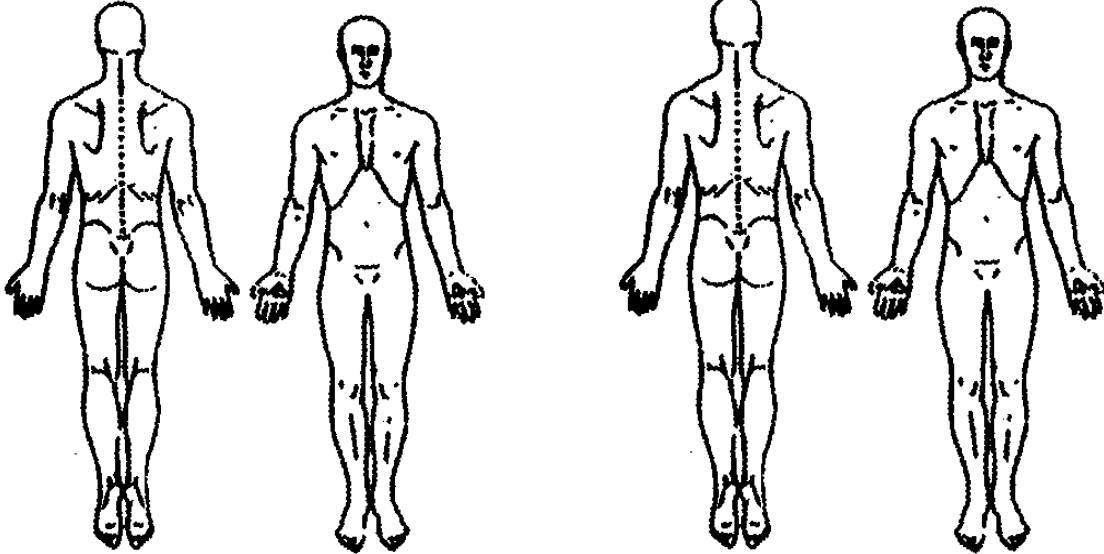
- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Self | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Employer | <input type="checkbox"/> Specialty Physician _____ | |
| <input type="checkbox"/> Case Manger | <input type="checkbox"/> Family Physician | <input type="checkbox"/> Occupational Medicine Clinic | |
| <input type="checkbox"/> Name (Optional) _____ | | | |

Date of onset: _____

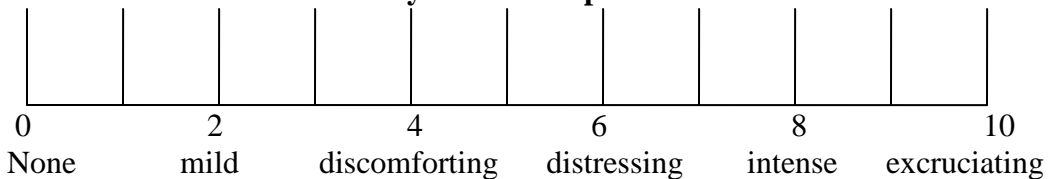
Describe your current disorder:

Show where you have pain:

Show where you have tingling or numbness:



Indicate your level of pain:



Which activities make your symptoms worse?

- | | | |
|-------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Walking | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Bending backward | _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Coughing | _____ |

Which activities make your symptoms better?

- | | | |
|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Walking | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Stretching | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Manipulation | _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Physical Therapy | _____ |

Who has treated you for this disorder?

- | | | |
|---|--|--|
| <input type="checkbox"/> No one | <input type="checkbox"/> Family Physician | <input type="checkbox"/> Occupational Medicine Physician |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Medical Neurologist | <input type="checkbox"/> Orthopedic Surgeon |
| <input type="checkbox"/> Company Doctor | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Osteopathic Physician |
| <input type="checkbox"/> ER Physician | | |

What treatments have been prescribed?

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Pain Management Program | <input type="checkbox"/> Other |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Pain Medication | _____ |
| <input type="checkbox"/> Brace | <input type="checkbox"/> Physical Therapy | _____ |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Work Hardening Program | _____ |
| <input type="checkbox"/> Manipulation | | |
| <input type="checkbox"/> Massage Therapy | | |

What testing has been done?

- | | | |
|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> EMG/NCV | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood Tests | <input type="checkbox"/> Functional Capacity Testing | _____ |
| <input type="checkbox"/> Bonescan | <input type="checkbox"/> MRI | _____ |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Myelogram | _____ |
| <input type="checkbox"/> DEXA Scan | <input type="checkbox"/> X-Rays | _____ |
| <input type="checkbox"/> Discography | | |

Are you being treated for the following medical conditions?

- | Y | N | | Y | N | | Y | N | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's/
Parkinson's | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Prostrate disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Headaches/migraine | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers/reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Vertigo/dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel | <input type="checkbox"/> | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Low back injury | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | Neck injury | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary artery disease | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral neuropathy | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | | | | | | _____ |

Have you had any of the following surgeries?

<input type="checkbox"/> Y	<input type="checkbox"/> N		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	
<input type="checkbox"/>	<input type="checkbox"/>	Appendix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate surgery
<input type="checkbox"/>	<input type="checkbox"/>	Bowel or colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder/rotator cuff
<input type="checkbox"/>	<input type="checkbox"/>	Cancer surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac cath	<input type="checkbox"/>	<input type="checkbox"/>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Carpel tunnel	<input type="checkbox"/>	<input type="checkbox"/>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Cataract/eye	<input type="checkbox"/>	<input type="checkbox"/>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Colonoscopy/EGD	<input type="checkbox"/>	<input type="checkbox"/>			_____
<input type="checkbox"/>	<input type="checkbox"/>	Coronary bypass	<input type="checkbox"/>	<input type="checkbox"/>			_____
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			

Do you have allergies to any medication?

No
 Yes (Please List)

Do you have any contact, food or dye allergies?

No
 Yes (Please List)

Are you taking medications, including pain medication?

No
 Yes (List with dosages)

Which of the following conditions have your family members had?

<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Neurologic conditions	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neuropathy	_____
<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Stroke	_____

Do you currently smoke cigarettes?

No, never
 No, I quit (when) _____
 Yes: ¼ ½ ¾ 1 1 ½ 2 3 packs per day

Do you currently consume alcoholic beverages?

No Monthly Daily
 Rarely Weekly

Do you currently consume caffeinated beverages?

No 1-2 drinks daily
 Rarely More than 2 drinks daily

How much exercise do you get on a regular basis?

None 2-5 times per week Competitive athlete
 Weekly Daily Professional/ elite

Occupation:

- Unemployed
- Homemaker
- Retired

- Student
 - Permanently disabled
 - Temporarily disabled
- Since: _____ (date)

- Employed part time
- Employed full time

Employer: _____

Job title/description: _____

Education:

- Did not complete grade School
- Completed grade school
- Completed some high School

- Currently in high school
- G.E.D.
- High School graduate
- Completed some college
- Currently in college

- Trade School graduate
- College graduate
- Professional school graduate

Describe your level of stress

- None
- Low

- Medium
- High

- Very High

Have you had any of the following symptoms or conditions?

- Abdominal Pain/ heartburn
- Chronic pain
- Difficulty Swallowing
- General Fatigue
- Hearing Impairment

- Impaired Coordination
- Impaired sexual function
- Impaired sleep patterns
- Loss of bladder/bowel control
- Vision/balance changes

- Weakness
- Weight gain
- Weight loss

Please add any other comments:

Patient's Signature: _____ Date: _____

Physician's Signature: _____ 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
------	--------------	--------------

Name	Relationship	Phone Number
------	--------------	--------------

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 services 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 Orthopaedics
Summit Woods Complex
500 E-Business Way
Sharonville, Ohio 45241
513-354-3700**

From I-75

Take I-275 East to Reed Hartman (Exit #47)

Stay in middle lane on exit ramp and follow signs to Kemper Road.

Turn right on Reed Hartman and *immediately* get into the left lane for Kemper Road Connector.

Turn left at the first traffic signal. This will take you up a short hill to Kemper Road and by the Double Tree Inn.

Turn right (east) on Kemper to second traffic signal, which is E-Business Way.

Turn left to Beacon Orthopaedic Center at 500 E-Business Way.

From I-71

Take I-275 West to Reed Hartman (Exit #47).

Turn left and cross over the interstate.

Once over the interstate, Reed Hartman turns into two lanes. *Stay in the left lane.*

Turn left at first traffic signal. This will take you up a short hill to Kemper road and by the Double Tree Inn.

Turn right (east) on Kemper to second traffic signal, which is E-Business Way.

Turn left to Beacon Orthopaedic Center at 500 E-Business Way.

**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

