



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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Patient History Form for Dr. Robert Burger

Patient Name (print): _____ Date of Birth: _____
 Gender: Male Female Marital Status: Single Married Divorced Widowed
 Race: _____ Ethnicity: _____ Preferred Language: _____
 Referred to Dr. Burger by: Self Family Physician Attorney Other: _____
 Name of Person(s) making referral: _____

Reason for your visit today? (Check all that apply) Pain Weakness Loss of motion Other

Reason for visit (Body part): _____ Right Left Both

How did your symptoms start? _____

When did your symptoms start? _____

Is this a new (acute) injury? Yes No Is this an old (chronic) condition? Yes No
 Is this a sports related injury? Yes No If yes, list School & Sport(s) _____
 Is this a work related injury? Yes No Is this a result of a motor vehicle accident? Yes No

On a scale from 0-10 how would you rate your pain level? (Circle answer):
 (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Please Circle the following which best describes the nature of your pain (circle all that apply)
 Sharp Dull Stabbing Throbbing Aching Burning Other: _____

Please circle the timing of your symptoms (circle all that apply):
 Constant Intermittent (Comes and Goes) Pain only with activities Pain wakes you from sleep

Please circle any associated symptoms you have experienced (circle all that apply):
 Swelling Stiffness Instability Giving Way Numbness Tingling Popping Clicking Catching

What makes symptoms better? _____

What makes symptoms worse? _____

Has this condition been evaluated by a Doctor? Yes No If yes, who and when: _____

What has been done for this condition?(circle all that apply):
 Medications Rest Ice Heat X-rays MRI CT Physical Therapy Injection(s)

PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE SYMPTOMS LISTED BELOW:

Constitutional:

- Fever
- Weight loss
- Fatigue
- Weakness
- Dizziness

Gastro-Intestinal:

- Ulcer
- Frequent heartburn
- Reflux
- GI Bleeding

Urinary:

- Prostrate problems
- Kidney Stones
- Chronic infections
- frequent urination

Cardiovascular:

- Chest Pain or angina
- Shortness of breath
- Heart murmur
- Heart attack
- Irregular heartbeat
- Fainting or syncope

Surgical:

- Ankle swelling
- Rheumatic fever
- Anesthesia problems
- Wound healing problems

Psychological:

- Depression
- Anxiety disorder
- Memory problems

Respiratory:

- Asthma
- COPD
- Lung disease
- Pneumonia
- Tuberculosis

Hematologic:

- Anemia
- Poor Circulation
- Phlebitis
- Blood clots
- Excessive bleeding
- Blood transfusion

Allergy/Immune:

- Seasonal Allergies
- Skin conditions

Musculoskeletal:

- Joint pain
- Joint swelling
- Muscle weakness
- Muscle tenderness
- Muscle spasms
- Morning stiffness
- Rheumatoid arthritis
- Osteoporosis
- Gout

Neurological and ENT:

- Seizures or epilepsy
- Stroke or TIA
- Headaches
- Trembling or Tremor
- Balance problems
- Hearing or vision loss



PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE OR HAVE BEEN TREATED FOR:

- | | | | |
|-------------|---------------------|---------------|----------------------------|
| AIDS/HIV | COPD | Depression | Hepatitis |
| Alcoholism | Colon Cancer | Diabetes | Kidney Disease |
| Alzheimer's | Lung Cancer | Drug Abuse | Osteoarthritis |
| Anemia | Breast Cancer | Gout | Seizures |
| Asthma | Prostate Cancer | Heart Disease | Ulcers |
| Blood Clots | Cancer (type) _____ | Hypertension | Osteopenia or Osteoporosis |

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

Who is your Medical Doctor? _____

What is your current height? _____ What is your current weight? _____

Do you have any allergies to medication? Yes No If yes, list medication(s) and reaction: _____

Are you allergic to nickel or any metals? Yes No Do you have any metal in your body? Yes No

Are you allergic/sensitive to latex? Yes No Are you allergic/sensitive to adhesive tape? Yes No

List any previous surgeries or overnight hospital stays (Please include year): _____

PLEASE CIRCLE THE FOLLOWING CONDITIONS YOUR IMMEDIATE FAMILY (MOTHER, FATHER OR SIBLINGS) HAVE BEEN TREATED FOR:

- | | | | |
|-------------|---------------------|---------------|----------------------------|
| AIDS/HIV | COPD | Depression | Hepatitis |
| Alcoholism | Colon Cancer | Diabetes | Kidney Disease |
| Alzheimer's | 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 other conditions: _____

Which hand do you write with? Right Left Are you retired? Yes No

What is your occupation or job title? _____

Are you currently employed? Yes No Who is your employer? _____

Circle the best description of your previous education (circle one):

Graduate School College graduate Some college HS Graduate GED Technical Training

Do you use tobacco? Yes No Former If yes, which type? Chewing Cigar Cigarettes Pipe

Please list amount and duration: (example 1 pack a day for 20 years) _____

Do you consume alcohol? Yes No Former: Do you consume caffeine? Yes No

Please list amount and duration: (example 2 sodas a day or alcohol socially) _____

How would you describe your activity level? (Circle one): Above average Average Sedentary

How frequently do you exercise? (Circle one)

2-3 times/week 3-4 times/week 5 times/week Daily Never Occasionally

Which physical activities or sports are you involved with? _____

Please list your hobbies or activities: _____

Please list any additional information which you think we might need to know to provide you with the best care possible: _____

Patient signature: _____ Date: _____

Physician signature: _____

**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 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 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