



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

BEACON ORTHOPAEDICS & SPORTS MEDICINE

Name: _____ Age: _____ D.O.B. _____ Date: _____

Chief Complaint: _____

Was this due to an injury? Yes ___ No ___ Date of Injury _____ Did this occur at work? Yes ___ No ___

Has the injury been treated? Yes ___ No ___ If yes, how has this been treated and by whom? _____

Have you had a previous similar injury? Yes ___ No ___ Please explain: _____

Current Weight: _____ 1 year ago _____ Height _____ Blood Pressure _____ Occupation: _____

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

Marital Status: S ___ M ___ W ___ D ___ Do you live alone? Yes ___ No ___ Hobbies/Sports: _____

Do you Smoke? Quit ___ Yes ___ No ___ If yes how many per day? _____ Total years you have smoked? ___ Have you ever tried to quit? Y ___ N ___

Do you consume alcohol? Yes ___ No ___ If yes how much per week? _____

Name of Primary Care Physician: _____

Drug Allergies: _____

Latex Allergy? Yes ___ No ___

Current Medications: _____

Hospitalizations or Previous Surgeries: _____

Past Medical Problems: _____

Have you ever had a blood transfusion? ___ yes ___ no If yes give date: _____

PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions? (Please check all that apply):

	Self		Mother		Father		Children/Other Relatives		
	Yes	no	Yes	no	Yes	no	Yes	no	
Heart Disease	___	___	___	___	___	___	___	___	For Women Only: Pregnant: Yes ___ No ___ Last Menstrual Period: _____
High Blood Pressure	___	___	___	___	___	___	___	___	
Stroke	___	___	___	___	___	___	___	___	
Cancer	___	___	___	___	___	___	___	___	
Glaucoma	___	___	___	___	___	___	___	___	
Diabetes	___	___	___	___	___	___	___	___	Are there any other serious illnesses /health conditions affecting you or your family of which we should be aware? Yes ___ No ___ _____ _____
Epilepsy/Convulsions	___	___	___	___	___	___	___	___	
Bleeding Disorder	___	___	___	___	___	___	___	___	
Thyroid Disease	___	___	___	___	___	___	___	___	
Mental Illness	___	___	___	___	___	___	___	___	
Osteoporosis	___	___	___	___	___	___	___	___	
Tuberculosis	___	___	___	___	___	___	___	___	
Kidney Disease	___	___	___	___	___	___	___	___	

Please check if you have ever had the symptom listed – Check all that apply

<u>Constitutional</u>	<u>Eyes</u>	<u>ENT/Mouth</u>	<u>Cardiovascular</u>	<u>Respiratory</u>
___ Fever	___ Double Vision	___ Deafness	___ Chest Pain	___ Shortness of Breath
___ Weight Loss	___ Blurring	___ Sinusitis	___ Heart Murmur	___ Asthma
___ Fatigue	___ Trauma	___ Ringing in Ears	___ High Blood Pressure	___ Lung Disease
		___ Dizziness	___ Heart Attack	___ Bronchitis
		___ Balance Problems	___ Irregular Rhythm	___ Pneumonia
<u>GI</u>	<u>GU</u>	<u>Musculoskeletal</u>	<u>Neurological</u>	<u>Psych</u>
___ Weight Change	___ Leaking Urine	___ Fracture	___ Seizures/Epilepsy	___ Depression
___ Diarrhea	___ Prostate Disease	___ Pain	___ Weakness	___ Sleep Disorder
___ Constipation	___ Pain with Urination	___ Swelling	___ Stroke	___ Memory Problems
___ Ulcer	___ Frequent Urination	___ Arthritis	___ Headaches	
___ Gallbladder Disease	___ Kidney Stones	___ Spasm/Muscle	___ Blackouts/Fainting	
___ Change in Bowel Habits		___ Gout	___ Tremble	
		___ Rheumatoid Arthritis	___ Head Injuries	
<u>Vascular</u>	<u>Hematologic</u>	<u>Allergy/Immunology</u>	<u>Skin/Breast</u>	
___ Blood Clots	___ Hepatitis	___ Hay Fever	___ Breast Abnormality	
___ Poor Circulation	___ Anemia	___ Dermatitis	___ Change in Skin/Hair	
	___ Lymph Node			
	___ AIDS			

Patient Signature _____ Date _____

Reviewed By _____ MD Date _____

Note: This is a confidential Record of your medical history and will be maintained in this office. The information contained here will not be released to any person except who you have authorized to do so.

**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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_____	_____	_____
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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: _____