BEACON
Orthopaedics & Sports Medicine

An OrthoAlliance Partner Practice

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 on the left side 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)

☐ Neck & radiates to	☐ R Arm ☐ L Arm	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
☐ Back & radiates to	☐ R Leg ☐ L Leg	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ 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 ☐ Tinglling ☐ 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)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Problems	☐ Blood Clots	☐ Asthma
☐ Bronchitis	☐ Emphysema	☐ Kidney Problems	☐ Hepatitis	☐ Thyroid Disease
☐ Ulcers	☐ Seizures	☐ Stroke	☐ Tuberculosis	☐ 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 you 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 you 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 Orthpaedic 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: _____

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Patient Name: _____ DOB: _____

Medications List

Allergies

_____ _____

_____ _____

Please list any medications you are currently taking

Drug Name	Dosage	Directions	Reason Taking

Preferred Pharmacy:_____ Date:_____
Location/Number:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices (HIPAA information). This notice provides a complete description of the uses and disclosures of my health information.

Patient Name: _____ Date of birth: _____

_____ _____
*Patient or Representative Signature Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient
(ex: parent, power of attorney)

**If the patient is a minor child or otherwise unable to sign this authorization, then obtain the signature of the authorized individual. If person is POA, we must have a copy of the Power of Attorney paperwork.*

Consent to Be Contacted

Beacon Orthopaedics & Sports Medicine, or third parties on our behalf, may need to contact you regarding your healthcare or your account with us. Those communications may include appointment and exam confirmation and reminders, wellness checkups, pre-registration instructions, pre-operative instructions, post-discharge instructions, post-appointment follow-up, prescription notifications, and other messages relating to your care, scheduling, benefits, billing, payment, or other financial responsibilities. By providing your phone number, you agree to receive calls or text messages from Beacon Orthopaedics & Sports Medicine, or a third party on its behalf, at the number you have provided. Such calls may be placed using an automatic telephone dialing system.

Please provide your preferred contact information below.

Name: _____

Cell Phone Number: _____ Home Phone Number: _____

☐ I would like to receive emails from Beacon Orthopaedics & Sports Medicine regarding new services, educational content, events, and other content related to orthopaedic conditions/treatment options.

Email Address: _____

Designation of a Personal Representative Form

Patient Name: _____ **Date of Birth**:_____

A patient **may** designate a personal representative in writing. This person may be a spouse, adult child, members of the patient's family, or close friend. They may also be 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. As a general rule, a parent or legal guardian of a minor child will be recognized as their personal representative.

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. 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.

***Please note*: This form does not grant permission to release medical records to these designated representatives.**

Person(s) to whom my information may be disclosed:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Patient/Representative Signature: _____ Date: _____

If patient is a minor, please provide the following information:

Mother's Name: _____
AND
Father's Name: _____

OR Legal Guardian(s): _____

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. Revised March 2019.

Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy

Effective April 2009

Patient Name: _____ Patient Date of Birth: _____

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 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, American Express, Discover 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 change 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 the purpose 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 or 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 returned checks**. You will be asked to bring cash, money order or cashiers 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 a 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.

Name - Person Completing Form (Print): _____ Birthdate of Person: _____

Signature - Person Completing Form: _____ Date: _____

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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 ahead up the hill 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 ahead up the hill 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 ahead up the hill 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 ahead up the hill to Beacon Orthopaedics

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Directions to

Beacon Lawrenceburg

605 Wilson Creek Rd, Lawrenceburg, IN 47025
513-354-3700

COMING FROM THE WEST ON I-74
Take the Lawrenceburg/St. Leon Exit (Exit #164)
Turn Right onto IN 1 S (13.4 miles)
Turn Right onto US 50 W (3 miles)
Turn Right onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

COMING FROM OHIO ON I-74
Take I-275 South towards Kentucky
Take the Lawrenceburg exit (Exit #16)
Turn Left onto US 50 W (3 miles)
Turn Right onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

COMING FROM OHIO ON I-275
Take the Lawrenceburg Exit (Exit #16)
Turn Left onto US 50 W (3 miles)
Turn Right onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

COMING FROM KENTUCKY ON I-275
Take the Lawrenceburg exit (Exit #16)
Turn Left onto US 50 W (3 miles)
Turn Right onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

COMING FROM CLEVES / NORTH BEND / ADDYSTON / DELHI
Take US 50 W (River Road)
Turn Right onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

COMING FROM MILAN
Take IN 350 East (13.1 miles)
Turn Left onto US 50 East (3.4 miles)
Turn Left onto IN 48 (2.3 miles)
Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

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

From Cincinnati:

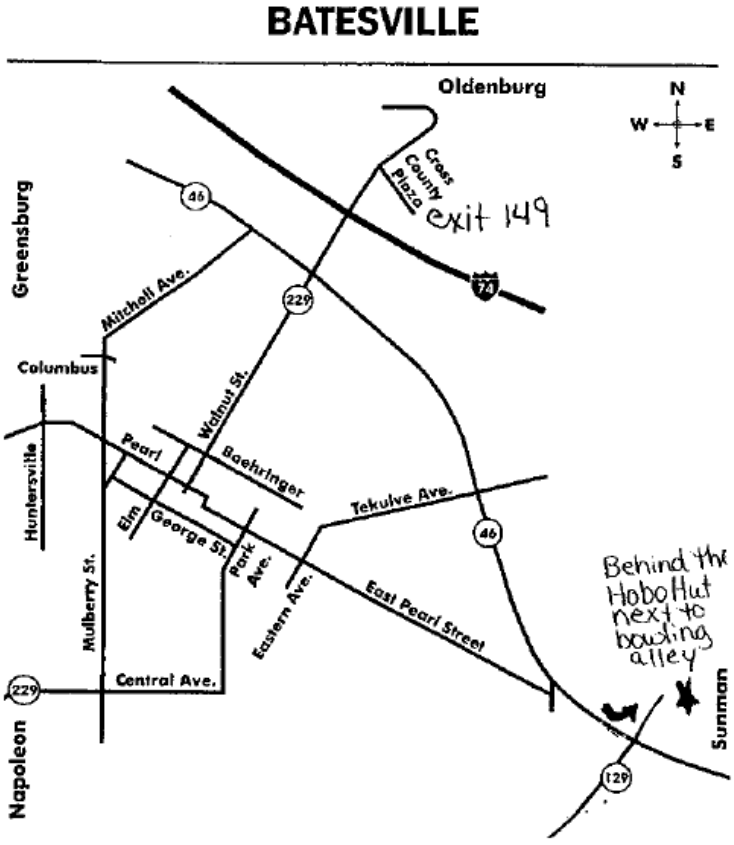
- Take I-74 West, into Indiana
- Take Exit 149,Batesville/Oldenburg
- Turn left on IN 229, .2 miles
- Turn left on IN 46, travel 1.5 miles, Junction 129
- Turn left at the light, office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

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



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