

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.

## Beacon Orthopaedics and Sports Medicine Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Married: ☐ Yes ☐ No

Name of Family Physician: \_\_\_\_\_

Who referred you to this office?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Self                | <input type="checkbox"/> Spine Surgeon                   | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Advertisement       | <input type="checkbox"/> Occupational<br>Med/Urgent Care | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Family Physician    |  | _____                                   |
| <input type="checkbox"/> Orthopaedic Surgeon | <input type="checkbox"/> Chiropractic Physician          | _____                                   |

Referring Physician: \_\_\_\_\_ Date of onset: \_\_\_\_\_

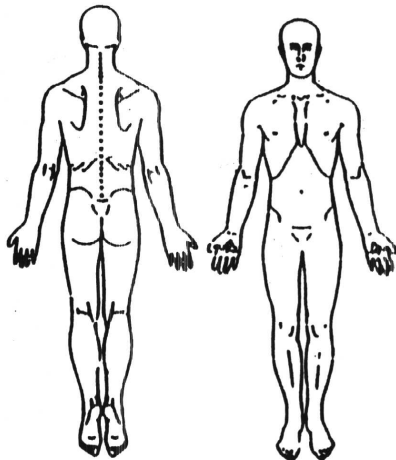
Describe your current disorder:

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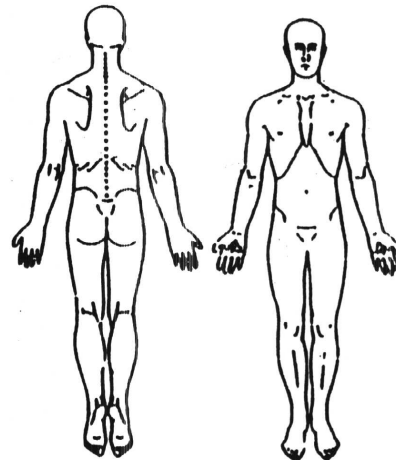
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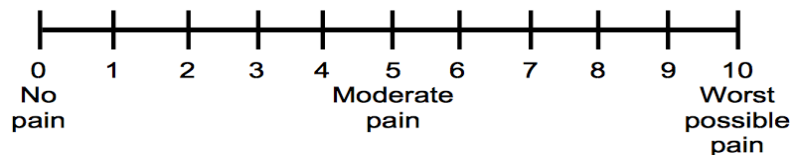
Show where you have pain:



Show where you have tingling, numbness or burning:



Indicate your level of pain:



Which activities or positions make you symptoms worse?

- |                                   |  |                                       |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Lying    | <input type="checkbox"/> Forward bending     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Backward bending    | _____                                 |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Coughing/sneezing   | _____                                 |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Getting up and down | _____                                 |

Which activities, treatments or positions make your symptoms better?

- |                                     |  |                                       |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Nothing    | <input type="checkbox"/> Spinal manipulation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lying      | <input type="checkbox"/> Physical therapy    | _____                                 |
| <input type="checkbox"/> Sitting    | <input type="checkbox"/> Medication          | _____                                 |
| <input type="checkbox"/> Standing   | <input type="checkbox"/> Injected medication | _____                                 |
| <input type="checkbox"/> Exercise   | <input type="checkbox"/> Surgery             | _____                                 |
| <input type="checkbox"/> Stretching |  |                                       |

What treatments have been prescribed or done?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> None             | <input type="checkbox"/> Massage therapy   | <input type="checkbox"/> Work reconditioning |
| <input type="checkbox"/> Injections       | <input type="checkbox"/> Pain mgt. program | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Surgery          | <input type="checkbox"/> Medication        | _____  |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Bracing           | _____  |

What testing has been done recently?

- |                                 |                                    |                                       |
|---------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> CT Scan   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Bone scan |                                       |
| <input type="checkbox"/> MRI    | <input type="checkbox"/> EMG/NCV   |                                       |

Are you being treated for any of the following disorders?

- | Y                        | N                        |                          | Y                        | N                        |                         | Y                        | N                        |                               |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's/Parkinson    | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                | <input type="checkbox"/> | <input type="checkbox"/> | Vascular disease              |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or Depression    | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia            | <input type="checkbox"/> | <input type="checkbox"/> | Prostate or thyroid disease   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis of hip or knee | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                | <input type="checkbox"/> | <input type="checkbox"/> | Seizures                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Disease      | <input type="checkbox"/> | <input type="checkbox"/> | Headache/Migraine       | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/reflux/irritable bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots/anemia       | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/aneurysm               |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                   | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol        | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure           |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary Artery Disease  | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease          | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Neuropathy    | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis            |                          |                          |                               |

Have you had any of the following surgeries?

- | Y                        | N                        |                  | Y                        | N                        |                   | Y                        | N                        |                         |
|--------------------------|--------------------------|------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer surgery   | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy      | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker/Defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary bypass  | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back surgery | <input type="checkbox"/> | <input type="checkbox"/> | Neck surgery      |                          |                          |                         |

Do you have any allergies to medications?

- ☐ No
- ☐ Yes: \_\_\_\_\_

Do you have any allergies to food or topical substances?

- ☐ No
- ☐ Yes: \_\_\_\_\_

Are you taking medications regularly?

- ☐ No
- ☐ Yes: \_\_\_\_\_

Which of the following disorders have your family members had?

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Neurologic disorders |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke               |

Do you currently smoke cigarettes?

- ☐ No, never
- ☐ No, quit: \_\_\_\_\_
- ☐ Yes: ☐ 1/4 ☐ 1/2 ☐ 3/4 ☐ 1 ☐ 1 1/2 ☐ 2 ☐ 3 packs per day

How much regular exercise do you get?

- |                                 |   |   |
|---------------------------------|---|---|
| <input type="checkbox"/> None   | <input type="checkbox"/> 2-5 times per week | <input type="checkbox"/> Competitive athlete  |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Daily              | <input type="checkbox"/> Professional athlete |

Occupation:

- ☐ Student  
☐ Homemaker  
☐ Retired

- ☐ Employed full time  
☐ Employed part time  
☐ Permanently disabled

☐ Temporarily disabled  
since: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Have you had any of the following conditions or symptoms?

Y N

- ☐ ☐ Impaired swallowing  
☐ ☐ Impaired hearing  
☐ ☐ Impaired vision  
☐ ☐ Impaired balance

Y N

- ☐ ☐ Impaired coordination  
☐ ☐ Impaired sleep  
☐ ☐ Loss of bladder control  
☐ ☐ Loss of bowel control  
☐ ☐ Impaired memory

Y N

- ☐ ☐ Weight gain  
☐ ☐ Weight loss  
☐ ☐ Rashes

Please add other comments:

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Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed:

☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_

Please list any medications you are currently taking



## 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.***

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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: \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

PAIN MEDICATION POLICY  
BEACON ORTHOPAEDICS AND SPORTS MEDICINE

The purpose of this agreement is to prevent any misunderstanding about the distribution of medications from the Beacon Orthopaedics and Sports Medicine physicians. Please initial each line on this form and sign at the bottom. As a Beacon physician, we are responsible for diagnosis and treatment of immediate orthopaedic related pain and complications.

\_\_\_\_\_ As such, the physicians do NOT prescribe long-term medication prescriptions to their patients.

\_\_\_\_\_ Any long-term medication use, be it narcotic, non-narcotic, or anti-inflammatory, must be obtained through a Primary Care Physician, or other designated provider.

\_\_\_\_\_ I will make and keep appointments as recommended. If I miss an appointment or do not schedule an appointment as recommended, I may not receive a refill of medication.

\_\_\_\_\_ I will continue treatment plans as advised including therapy, injections, or follow-up appointments, if other treatments are discontinued medications may not be refilled.

\_\_\_\_\_ As the patient, please understand medication provided should not be used at a more accelerated rate than originally prescribed, as this may result in being without medication for a period of time should violations occur.

\_\_\_\_\_ I understand that with the use of prescription monitoring software, your physician may verify if pain medication is being administered by any other source while being prescribed one of our physicians.

\_\_\_\_\_ I agree refills of prescriptions must be requested during regular office hours. No refills will be given after hours or on weekends.

\_\_\_\_\_ If a medication will need to be refilled over the weekend, please request the prescription by Thursday.

\_\_\_\_\_ We request at least 24-hour notice for all refill authorizations, so as to ensure arrangements can be made.

I, \_\_\_\_\_, understand these guidelines as described above and agree to follow the policy outlined in this document. I also understand the benefits and risks of the use of an opioid analgesic, including the potential risk of addiction.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Orthopaedics & Sports Medicine

**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 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

## 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

