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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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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New Patient Background Information – Dr. Atul Chandoke

Name: _____

Date of Birth: _____

Primary reason you are coming into the office today: _____

Referring Doctor: _____

Primary Care Doctor: _____

Additional doctors to whom you would like us to send notes to: _____

_____

Previous Tests: (please check)

___ MRI _____X-Rays _____ CT Scan _____EMG/NCV

___ Other (specify) _____

Previous Treatments: (please check)

___ Epidural Injections ___ Trigger Point Injections ___ Tens Unit

___ Chiropractor ___ Radiofrequency ___ Psychologist

___ Physical Therapy ___ Massage Therapy ___ Other (specify)

_____

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Detailed Patient History

Name: _____DOB: _____ Age:_____

Chief Complaint: _____

Was this due to an accident? ___yes___no. Date of Accident:_____

Did this occur while at work? ____ yes ____ no.

Has this problem been treated before? ___yes ___no.

If yes, when and by whom? _____

Current Weight _____ 1 year ago _____ Height: _____ BP: _____

Gender: _____ Race: _____ Marital Status: _____

Occupation: _____

Do you smoke: _____ If yes, how many per day? _____ How long? _____

Do you consume alcohol? _____ If yes, how much per week? _____

Do you consume caffeine? _____ If yes, how much? _____

Have you ever received treatment for substance abuse? _____

If yes, when and where? _____

Have you ever received treatment for alcohol abuse? _____

If yes, when and where? _____

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Name: _____DOB: _____

We will be discussing your primary reasons for being referred to us in detail. It is helpful to understand any additional symptoms you are currently experiencing.

Please check off any of the following symptoms you are having:

____ Abdominal Pain

____ Anxiety

____ Chest Pain

____ Constipation

____ Depression

____ Diarrhea

____ Difficulties with sexual function/intercourse

____ Excessive cough

____ Excessive weight gain

____ Excessive weight loss

____ Hearing loss

____ Insomnia

____ Nausea/vomiting

____ Rash

____ Ringing in ears

____ Unexplained fever (outside of an illness such and cold or flu)

____ Vision loss

For women only:

_____ Extremely painful menstrual cycles

____ Irregular cycles Date of last menstrual cycle _____

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Name: _____ DOB: _____

Have you or any of your immediate family members had any of the following?

___ **Heart Disease** ___self ___ mother ___father ____other

___ **High Blood Pressure** ___self ___mother___ father ____other

___ **Stroke** ___ self ____mother _____father ____ other

___ **Cancer** ___ self ____mother _____ father ____other

___ **Glaucoma** ____self ____mother _____father ____other

___ **Diabetes** ____self ____mother _____father ____ other

___ **Epilepsy/Seizures** ____ self _____mother _____father ____other

___ **Bleeding Disorder** ____self ____mother _____father ____other

___ **Thyroid Disease** ____self ____mother ____father ____other

___ **Mental Illness** _____self ____mother ____father ____other

___ **Osteoporosis** ____self ____mother ___father ____other

___ **Tuberculosis** ____self ____mother ____father ____other

___ **Kidney Disease** ____self ____mother _____father ___other

___ **Other** ____self ____mother _____father ____other

Please list all previous surgical procedures:

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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2021 Opioid Contract –Informed Consent- Office Care Guidelines

The following is an agreement between the patient and Beacon Orthopaedics & Sports Medicine concerning the use of controlled substance medication, informed consent for the prescribing of controlled substances, as well as office guidelines for continued care. By signing this form, you are agreeing to follow the guidelines set forth by this practice. Failure to comply can result in termination of the patient-provider relationship and possible notification to Federal, State, or Local Law Enforcement authorities if a crime is believed to have been committed with your failure to comply with this agreement.

PLEASE INITIAL ALL AREAS. Your initials certify that you agree to all policies of the office. Non-compliance may result in the discontinuation of care at our facility.

_____1. I understand that controlled substance medication is for my use only. I will not share my medication with any other person.

_____2. I understand that selling or sharing my prescribed medications is illegal and is a Felony Crime.

_____3. I understand that I cannot use an illegal drug, drink alcoholic beverages, or use another's prescribed medications while I am a patient at Beacon Orthopaedics & Sports Medicine.

_____4. I understand that if I lose or misplace my medication, it may not be replaced.

_____5. I will safeguard my medication from theft by using a lockbox at my home, this protects myself and others around me. Stolen medication may not be replaced.

_____6. I understand that my controlled substance prescriptions can only be filled at ONE pharmacy.

Name of Pharmacy_____
Location/Phone Number_____

_____7. I understand that I CANNOT obtain a controlled substance medication from any other physician/hospital/urgent care/ or medical provider without the permission of Dr. Chandoke. I understand that in the event of an emergency after hours, I will seek care at the nearest emergency treatment facility or contact my general physician. Dr. Chandoke should be contacted as soon as reasonably possible after seeking emergency medical care. No controlled substance medication prescription may be filled without the express permission of this practice. Controlled medications professionally administered inside a hospital setting are exempt from this requirement, but do need to be reported to Dr. Chandoke at your earliest convenience.

_____8. I understand that my controlled substance prescriptions can ONLY be refilled during a scheduled office/telehealth appointment.

_____9. I understand that Dr. Chandoke ONLY fills 30 day prescriptions. You will not be allowed to fill a controlled substance prescription any earlier than 30 days from the last fill date. Medications may not be filled early.

_____10. I will take my medications as prescribed by the provider who prescribed the medication. No medication adjustments can be made without consulting with and obtaining permission from Dr. Chandoke first. It is acceptable for you to take less medication if your pain level is lower, but you should never take more than the prescribed amount to minimize accidental overdose risks.

_____11. I will only take controlled substance medications that are currently prescribed by this practice. I understand that under no circumstance may I take an old, expired, or additional controlled substance prescription.

_____12. I will not dispose of my controlled substance medication myself. Disposal of medication can only be done by a medical representative at our facility, or at a facility approved by this practice.

_____13. **I understand that if I am going out of town, I must schedule my travel times around my medication refill dates. **Medications may not be refilled early!

_____14. I understand and agree that I am subject to random urine drug screen tests and/or pills counts at my physician's request and that I **MUST** comply in order to obtain my monthly prescription and/or continue care at Beacon Orthopaedics & Sports Medicine.

_____15. I understand that my treatment at Beacon Orthopaedics & Sports Medicine is private and I will not share my plan of care or medication information with other patients. This is for the safety of you and your family.

_____16. I understand that it is my responsibility to make my medication appointment for my next medication refill before I leave the office.

_____17. I understand that if I miss my medication refill appointment, that the office will only be able to offer their first available appointment. I understand I may be without medication for a short period of time.

_____18. I will immediately report to the staff of Dr. Chandoke if I am arrested or charged with any crime related to the abuse and\or selling of any prescribed or illegal drug. Failure to report your arrest may result in termination from the practice.

_____19. I agree to keep my billing account with in "Good Standings" at all time. I understand that failing to make timely payments on my account may result in a referral to a collection agency, weaning of my medications, and possible discharge from the practice.

_____20. I understand that honesty is part of the foundation of a good doctor-patient relationship in order to receive the best care possible. I agree to be completely honest with Dr. Chandoke's staff. I understand that failure to be honest with the staff will be considered a breakdown in the doctor-patient relationship and may result in my discontinuation of care.

_____21. I understand that for the safety of myself and others around me and in accordance with State Medical Board of Ohio Rules; this practice may issue me a prescription for a Naloxone product. I agree it is my duty to fill the prescription and keep it readily at hand in case of an accidental medication overdose.

_____22. I agree to be professional and courteous to the staff and providers at all times. Threats, yelling, cursing, and/or physical violence will not be tolerated and may result in my immediate termination from the practice and possible reporting to law enforcement.

_____23. I understand and agree that the providers of this practice have the ultimate medical decision concerning my treatment plan. Medical decisions will be made on best practices for the treatment of pain and with my personal health in mind. I agree to follow the treatment plan administered by my provider and understand that not following the treatment plan may result in my termination from the practice. This treatment plan may include controlled and non-controlled medications, physical or aquatic therapy, alternative treatments, psychological counseling, interventional procedures, surgical intervention, etc...

_____24. I understand that my future appointments may be conducted via telemedicine and I do hereby give my consent for the rendering of medical care via audio/video now and in the future.

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PLEASE INITIAL ACCORDING TO GENDER:

_____**Females**: If I am within child bearing age, I certify that I am not pregnant and will take appropriate measures to prevent pregnancy during the course of treatment. If I become pregnant, I will notify my provider at Interventional Pain Specialists immediately.

_____**Males**: I am aware that chronic opiate use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may do a blood test to check my testosterone level during my care at Interventional Pain Specialists.

Additional Compliance and Billing Topics: <u>PLEASE READ AND INITIAL</u>

_____1. **(Compliance) I understand that my controlled substance medications may be discontinued if...**

- If I test positive for an illegal substance on a urine drug screen test
- If I test negative for any prescribed medications on a urine drug test
- If I test positive for a medication that is not currently prescribed to me
- If I do not show up or have the correct medication count at mandatory pill count appointments
- If I NO SHOW or continually cancel office visit appointments or scheduled interventional procedures
- If my billing account becomes delinquent
- If I do not comply with treatment suggested by my provider
- If I do not cooperate in a civil manner with the staff or providers

_____2. **(BILLING) I understand that I have to have active medical insurance to be seen and obtain medications unless approved by Dr. Chandoke.**

- I must present my current insurance card if requested by the check in clerk.
- A government issued picture identification needs to be brought to all visits and procedures and may be asked for at random.
- Beacon Orthopaedics & Sports Medicine has the right to verify active insurance through the insurance company before your visit and require a cash deposit if unable to verify current coverage.
- If I have a co-pay, it MUST be paid before you are seen.
- I understand that Beacon Orthopaedics & Sports Medicine is not a creditor and although in hardship situations a payment plan may be extended to you, payments are generally due at the time of service.
- As allowed by law, No-Show fees may be charged for same day appointment and procedure cancellations. These fees must be paid in cash or credit and will not be billed to your medical insurance provider.

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_____3. **(Risks of Medication Use) I understand physical dependence is a normal expected outcome of using long term controlled substance medications.**

- I am aware that the tolerance to analgesia means that I may require more medicine or need to rotate medications to get the same amount of relief.
- I understand that the goal is to minimize controlled substance usage while controlling my conditions with interventional or therapeutic methods.
- I understand that opiate medications offer no disease modifying components and only treat the symptoms of your condition in the short term. Interventional treatment may be recommended for a more long-term direct relief approach to your condition.
- Dr. Chandoke reserves the right to intervene with controlled medication treatments by using therapeutic and/or interventional treatment methods to help lower the narcotic dose and relieve pain.
- I understand that there is a risk that opiate addiction may occur. This means that I may become psychologically dependent on the medication. If this occurs, the medication will be stopped and I will be referred to appropriate substance abuse treatment.
- I agree to minimize, safely wean, or discontinue use of Benzodiazepines if prescribed Opiates due to extreme risk of accidental overdose and black box warning by the FDA. **Benzodiazepines may not be prescribed by Dr. Chandoke on a long term basis.**
- I understand that the risks and side effects of opiate medications are:
  -Sedation, drowsiness, feeling sleepy
  -Confusion, change of ability to think clear
  -Difficulty with balance **–DO NOT operate heavy equipment or drive motor vehicles**
  -Constipation, nausea, vomiting
  -Decrease in respiration or breathing- Extreme risk of accidental overdose when taken with a benzodiazepine- Such as Ativan, Lorazepam, Xanax, Valium, Diazepam.

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By signing this agreement; I hereby agree that:

I have read, agreed to, and understand the aforementioned agreement.

I am fully aware that this contract and office policies are in place to assist with my safety, compliance, and well-being.

I am willing to comply with the individualized plan of care recommended by all providers at Beacon Orthopaedics & Sports Medicine.

I will fully comply with all aspects of this agreement until my care at Beacon Orthopaedics & Sports Medicine is discontinued.

I understand that this contract will be renewed yearly in order to continue care with Beacon Orthopaedics & Sports Medicine.

I hereby authorize my Pharmacy of Record to release any and all patient information to Beacon Orthopaedics & Sports Medicine staff for the purpose of medication compliance and my continued patient care.

I hereby authorize any past, present, or future medical treatment providers to release my personal medical information and patient medical records, at the request of Dr. Chandoke. I further authorize the medical treatment provider to discuss my medical treatment and/or medical care with Dr. Chandoke upon their request.

I agree that I have had ample opportunity to ask any questions regarding this agreement or my patient care with my provider to my satisfaction.

Printed Patient Name:_____ **Date:** _____

Patients Signature: _____

Staff Witness: _____

Provider Signature: _____

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 - 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL			_____	_____

Total Score Risk Category
Low Risk 0 - 3
Moderate Risk 4 - 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool.
Pain Medicine. **2005;6(6):432-442. Used with permission.**

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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: _____

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: _____