

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.

Dr. Matt Johansen's
PATIENT MEDICAL HISTORY FORM

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female Height: _____ Weight: _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: Right Left (indicate body part) _____

Date of Onset: _____ Injury Related: Yes No Work Related: Yes No

List activities that make it worse: _____

Previous treatment (therapy, injections, medications): _____

_____ Treating Physician: _____

Review of Systems: Do you currently have any of these symptoms?

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Rashes	<input type="checkbox"/> Depression
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Open Sores	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Weak Muscles
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Joint Stiffness
<input type="checkbox"/> Chills	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Cough	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Numbness	<input type="checkbox"/> Hair Loss	Other: _____
<input type="checkbox"/> Breath Shortness	<input type="checkbox"/> Upset Stomach	<input type="checkbox"/> Tingling	<input type="checkbox"/> Mood Swings	_____
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tremors	<input type="checkbox"/> Anxiety	_____

Past Medical History: Do you have currently or have you ever had?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Angina	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> TIA
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Arrhythmia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Heart Valve Disease	<input type="checkbox"/> Hiatal Hernia/Reflux	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	Other: _____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> HIV	<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers	_____
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Fractures	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stroke	_____

Have you ever had a blood clot? _____ If yes, when? _____

Past Surgical History: Please list any previous surgical history

Problems with anesthesia: Yes No Explain: _____

Problems with Foley/Bladder catheter: Yes No Explain: _____

Allergies: _____

Social History:

Do you smoke? Yes No Former

Occupation: _____

If yes, _____ packs per day for _____ years

Do you drink alcohol? Yes No

Where do you live: Home/Apt Retirement Community

If yes, how much? _____

Who do you live with _____

Family History: Do any diseases run in your family? Please List

MD Signature: _____



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: _____



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 Beacon East

463 Ohio Pike

Cincinnati, OH 45255

513-354-3700

From South of Cincinnati: I-75/I-71 North

- Take I-71/75 North to I-275 East
- Take the Beechmont Avenue exit 65 and turn left. Stay in the left hand lane.
- Turn left onto Hamblen Road (Bob Sumerel Tire and Olive Garden will be to the left)
- Parking is available on the side and front of the building

From Northern Cincinnati: I-75/I-71 South

- Take I-71/I-75 South to I-275 East
- Take the Beechmont Avenue exit 65 and turn right. Stay in the left hand lane
- Turn left onto Hamblen Road (Bob Sumerel Tire and Olive Garden will be to left)
- Parking is available on the side and front of the building.



Directions to Beacon

Northern Kentucky

600 Rodeo Drive, Erlanger KY, 41018

(513) 354-3700

From I-75/I-71 in Northern Kentucky:

- Take Exit 184 for KY - 236 toward Erlanger
- Follow KY- 236 West
- Turn right onto Houston Road
- Take first left onto Rodeo Dr.
Beacon NKY will be on your right

From I-275 in Northern Kentucky

- Take Exit 84 for I-75 S/I-71 N toward Lexington/Louisville
- Take Exit 184 for KY-236 toward Erlanger
- Follow KY- 236 West
- Turn right onto Houston Road
- Take first left onto Rodeo Dr.
Beacon NKY will be on your right



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 CLEVELAND / 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