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.

Name:
DOB:
Chart:
Age:
Date:

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PATIENT HISTORY FORM

Nickname: _____

Are you: ☐ Right handed ☐ Left handed ☐ Ambidextrous ☐ Male ☐ Female Height: _____ Weight: _____

Medical History: Do you currently or have had any of the following? ☐ **NONE**

☐ seizures	☐ stroke	☐ diabetes	☐ hypothyroidism
☐ congestive heart failure	☐ coronary artery disease	☐ heart attack	☐ heart murmur
☐ high blood pressure	☐ high cholesterol	☐ irregular heart beat	☐ pacemaker
☐ asthma	☐ COPD	☐ sleep apnea / CPAP	☐ reflux / heartburn
☐ stomach ulcers	☐ colitis	☐ Crohn's disease	☐ hepatitis / liver disease
☐ kidney disease _____	☐ arthritis	☐ chronic pain	☐ gout
☐ fibromyalgia	☐ osteomyelitis	☐ osteoporosis	☐ anemia
☐ bleeding disorder	☐ blood clots	☐ HIV / AIDS	☐ MRSA / VRE
☐ poor circulation	☐ cancer _____	☐ depression	☐ drug / alcohol problem
☐ psychiatric illness	☐ pregnancy (current)	☐ other / details _____	

Surgical History: ☐ **NONE.** Circle all that apply:

☐ Eyes / ENT: cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other _____
☐ Heart: bypass, valve replacement, stent, other _____
☐ Lung: resection, other _____
☐ Gastrointestinal: appendix, gall bladder, hernia, other _____
☐ Gynecologic: C-section, hysterectomy, tubal ligation, other _____
☐ Urologic: prostate, bladder, vasectomy, other _____
☐ Orthopaedic: joint replacement, arthroscopy, fracture surgery, spine, other _____
☐ Vascular: carotid, aneurysm, bypass, other _____
☐ Neurosurgical: aneurysm, tumor, craniotomy, other _____
☐ Cancer: skin, breast, thyroid, other _____
☐ Other: _____

Anesthesia Complications: ☐ **NONE.** If yes, explain: _____

Would you accept blood products or blood transfusions as needed at the discretion of your provider? ☐ yes ☐ no

Medications: ☐ **NONE** ☐ additional sheet attached ☐ Are you taking any blood thinners? ☐ Have you taken chronic steroids?

Medication (include over the counter medicines and nutritional supplements)	**Dose and Frequency**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Medical Allergies: ☐ **NONE** ☐ penicillin ☐ sulfa ☐ latex ☐ metals ☐ tape ☐ iodine (IV contrast) ☐ shellfish
☐ poultry products ☐ anti-inflammatories ☐ other _____

Name:
DOB:
Chart:
Age:
Date:

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Social History:

Alcohol Use: ☐ none ☐ occasional ☐ weekly ☐ daily

Tobacco Use: ☐ none ☐ previous When did you quit?_____ ☐ current packs / day: _____
When did you start?

Recreational Drug Use: ☐ none ☐ previous ☐ current drug _____ Last used?_____

Fall Assessment:

Have you fallen 2 or more times in the past year? ☐ yes ☐ no Have you seen anyone regarding your fall? ☐ yes ☐ no

Have you had any falls with injury in the past year? ☐ yes ☐ no

Other Current Symptoms: (within the last 4 weeks) ☐ **NONE.** Circle all that apply:

☐ yes ☐ no	Constitutional:	unexpected weight loss, weight gain, fever, chills, night sweats, fatigue	_____
☐ yes ☐ no	Eyes:	blurred /double vision, eye pain, redness, watering	_____
☐ yes ☐ no	ENT:	headache, difficulty swallowing, nose bleeds, ringing in ears, earaches	_____
☐ yes ☐ no	Cardiovascular:	chest pain, palpitations, fainting, murmurs	
☐ yes ☐ no	Respiratory:	shortness of breath, wheezing, coughing, painful breathing, snoring	_____
☐ yes ☐ no	Gastrointestinal:	heartburn, nausea, constipation, incontinence, diarrhea, bloody/black stools	
☐ yes ☐ no	Genitourinary:	urinary frequency, urgency, difficulty, pain, bleeding, incontinence	
☐ yes ☐ no	Musculoskeletal:	other joint pains, swelling, instability, stiffness, redness, heat, muscle pain	_____
☐ yes ☐ no	Skin:	skin changes, poor healing, rash, itching, redness, foot ulcers	
☐ yes ☐ no	Neurological:	numbness /tingling, unsteady gait, dizziness, tremors, seizures	
☐ yes ☐ no	Psychological:	nervousness, anxiety, depression, hallucinations, confusion	
☐ yes ☐ no	Hematologic:	easy bleeding, bruising	
☐ yes ☐ no	Endocrine:	excessive thirst or urination, heat / cold intolerance	
☐ yes ☐ no	Other:		

Family History (mother / father / siblings): ☐ **NONE OF THE BELOW**

☐ anesthesia complications
☐ arthritis _____
☐ bleeding disorder/blood clots
☐ cancer _____
☐ diabetes _____
☐ heart disease
☐ high blood pressure
☐ kidney disease
☐ thyroid disease _____
☐ other _____

Occupation: _____

My duties consist of:

Sitting: hours Standing:_____hours Lifting: pounds Repetitive Motion: ☐ yes ☐ no

Are you presently working? ☐ yes ☐ no If no, when was your last date worked?_____

Will your employer allow you to return to work with restrictions? ☐ yes ☐ no

If unemployed explain why: _____

Patient or Responsible Party Signature: Date:_____

Provider Signature: _____ Date:_____

Updated Signatures (if hx changed)

Patient or Responsible Party Signature: _____ Date:_____

Provider Signature: _____ 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 an Orthopaedic Surgeon and Sports Medicine 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.

_____ In the event surgical intervention is performed, we will ONLY prescribe narcotic pain medication for up to 2 prescriptions post-operatively, dependent upon the procedure.

_____ We may prescribe pain medication for severe or complicated fractures.

_____ 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

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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: _____

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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: _____