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.

PATIENT HISTORY
BEACON ORTHOPAEDICS & SPORTS MEDICINE

Name: _____ Age: ____ D.O.B._____ Date: _____
Height:_____ Weight:_____ Are you a smoker?:____Y ____N
Chief Complaint: _____
Was this due to an injury? Yes____ No____ Date of Injury _____ Did this occur at work? Yes _____ No _____
Has the injury been treated? Yes____ No ____ If yes, how and by whom? _____
Previous Surgeries or Hospitalizations?_____
Have you had a previous similar injury? Yes ____ No____ Please explain: _____
Name of Primary Care Physician: _____

PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Medical Conditions

Have **you (label as S)** or any **family members (label as F)** had the following history of symptoms or conditions listed below? (Please check all that apply):

__ Bleeding Disorder	__ Glaucoma	__ Kidney Disease	__ Stroke
__ Cancer	__ Gout	__ Liver Disease	__ Thyroid Disease
__ Diabetes	__ Heart Disease	__ Mental Illness	__ Tuberculosis
__ Epilepsy/Convulsion	__ High Blood Pressure	__ Osteoporosis	__ Other_____

Allergies to Medication, Allergen, or Latex

Please list any allergies to Medication, Allergens, or latex

Substance	Reaction	Substance	Reaction

Medications List

Please list any medications you are currently taking (If you need more space, please use the back of this form)

Drug Name	Dosage	Directions	Reason Taking

Preferred Pharmacy: _____ Date: _____

Location/Number: _____

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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: _____

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Designation of a Personal Representative

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.
PLEASE NOTE: 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. Requests for medical records must be made separately through the Medical Records department. Please allow approximately five business days to process a request for medical records.

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

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

Patient Name: _____ Date of birth:_____

Patient/Authority Signature: _____ Date: _____

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 2012 - 45 CFR 164.502(g)

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 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.

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Driving Directions to Beacon Orthopaedics
Miamisburg Location
2835 Miami Village Drive
Miamisburg, OH 45342
513-354-3700

From I-75 (Headed South)
Take exit 44 for OH-725 toward Centerville
Use the left 2 lanes to turn left onto OH-725 E/Miamisburg Centerville Road 0.5 miles
Turn Right onto OH-741 S/N Springboro Pike 2.1 miles
Turn left onto Miami Village Drive
Location will be on the left

From I-75 (Headed North)
Take exit 41 for Austin Blvd toward Miamisburg/Washington Township
Use the right 2 lanes to turn right onto Austin Blvd 0.3 miles
Use the left 2 lanes to turn slightly left toward OH-741 N 0.1 miles
Use any lane to turn left at the 1st cross street onto OH-741 N 0.8 miles
Turn right onto Miami Village Drive
Location will be on the left