

Physicians & Locations

David B. Argo, M.D.
John E. Bartsch, M.D.
Brian Braithwaite, M.D.
John J. Brannan, M.D.
Robert R. Burger, M.D.
Andrew P. Burleson, M.D.
Peter S. Cha, M.D.
Atul Chandoke, M.D.
Haleem N. Chaudhary, M.D.
Jaideep Chunduri, M.D.
Mohab B. Foad, M.D.
Nicole Goddard, D.O.
Todd E. Grime, M.D.
Steve C. Hamilton, M.D.
Ronald G. Hess, D.O.
Matthew A. Johansen, M.D.
Sam B.H. Koo, M.D.
Timothy E. Kremchek, M.D.
Matthew Langenderfer, M.D.
John J. Larkin, M.D.
David P. Lustenberger, M.D.
Alberto Maldonado, M.D.
George Matic, M.D.
Glen A. McClung II, M.D.
Timothy McConnell, M.D.
Adam G. Miller, M.D.
Joshua Murphy, M.D.
Michael P. Planalp, M.D.
Andrew Razzano, D.O.
Ian P. Rodway, M.D.
Michael T. Rohmiller, M.D.
Robert H. Rolf, M.D.
Brian A. Rottinghaus, M.D.
V. James Sammarco, M.D.
Kevin J. Shaw, M.D.
Aarti A. Singla, M.D.
Joel I. Sorger, M.D.
David Sower, M.D.
Henry A. Stiene, M.D.
Michael L. Swank, M.D.
M. Scott True, M.D.
Michael D. Wigton, M.D.

Administrative Office
50 E. Business Way, Suite 200
Sharonville, OH 45241

Summit Woods
500 E. Business Way
Sharonville, OH 45241

Batesville
1360 E. State Route 46
Batesville, IN 47006

Beacon East
463 Ohio Pike
Cincinnati, OH 45255

Beacon West
6480 Harrison Avenue
Cincinnati, OH 45247

Cincinnati Sports Club
3950 Red Bank Road
Cincinnati, OH 45227

Fairfield
5900 Boymel Drive
Fairfield, OH 45014

Lawrenceburg
605 Wilson Creek Road
Lawrenceburg, IN 47025

Lebanon
100 Arrow Springs Blvd.
Lebanon, OH 45036

Lebanon PT
440 Corwin Nixon Blvd.
South Lebanon, OH 45065

Liberty
8020 Liberty Way
West Chester, OH 45069

Miamisburg
2835 Miami Village Drive
Miamisburg, OH 45342

Montgomery
8099 Cornell Road
Cincinnati, OH 45249

Northern Kentucky
600 Rodeo Drive
Erlanger, KY 41018

Wilmington
720 Elm Street
Wilmington, OH 45177

BEACON

Orthopaedics & Sports Medicine

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.

David Argo, M.D.
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David Sower, M.D.
Henry Stiene, M.D.
Michael Swank, M.D.
M. Scott True, M.D.
Michael Wigton, M.D.

www.beaconortho.com

Phone: 513.354.3700

Fax: 513.354.3705



PATIENT INTAKE FORM

BEACON ORTHOPAEDICS & SPORTS MEDICINE

Full Name: _____ D.O.B: _____ Date: _____

Male/Female: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Height: _____ feet _____ inches Weight: _____

How did you find us? ☐ Internet Search ☐ Social Media ☐ Radio/TV ☐ Event ☐ Beacon Physician ☐ Other Physician ☐ Friend/Family Referral

Referring Physician Name/Phone/Address _____

Primary Physician Name/Phone/Address _____

Are you here for an injury? Yes ☐ No ☐ Date of Injury _____

Auto Accident Claim: Yes ☐ No ☐ Worker's Compensation Claim: Yes ☐ No ☐

(1) Please describe briefly the primary reason/problems for your visit: _____

(2) What is the number of weeks/months/years you have had this problem? _____

(3) Location of Problem (check all that apply): **Left** Foot ☐ Ankle ☐ Leg ☐ **Right** Foot ☐ Ankle ☐ Leg ☐

(4) If both sides bother you, which side is worse? Left ☐ Right ☐

(5) Check all that apply: Pain ☐ Numbness ☐ Feel unstable on your feet ☐

(6) Is the problem getting: Better ☐ Worsening ☐ Staying the same ☐

(7) What makes the problem better? _____

(8) What makes the problem worse? _____

(9) What does this problem limit you from doing? (Daily activities, tennis, work, etc) _____

(10) Rate your pain when it's at its worst on the following scale by circling a number below.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

(11) How far can you walk without stopping? Unlimited ☐ 5-10 blocks ☐ 1-5 blocks ☐ Less than 1 ☐

(12) Have you been using or tried in the past an assist device? None ☐ Splint or Cast from the ER ☐ Arch Supports ☐ Custom Foot Orthotics ☐ Special Shoes ☐ Ankle or Leg Brace ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐ Knee Walker ☐ Other: _____

(13) Fill in the therapies you have tried for your problem:

a. Medication by mouth: Yes ☐ No ☐

b. Steroid Injection: Yes ☐ No ☐ How many _____ Date of most recent _____

c. Did symptoms improve with last injection? Yes ☐ No ☐ For how long did symptoms improve? _____

d. For this problem have you tried acupuncture? Yes ☐ No ☐ Chiropractic? Yes ☐ No ☐

e. Physical Therapy? Yes ☐ No ☐ For how many weeks? _____

(14) Other Therapy? _____

Medical History – Check all that apply

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Connective tissue disorder	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Lymphoma, malignant	<input type="checkbox"/> Seizures
<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Heart Beat Irregularity	<input type="checkbox"/> Other Tumor, malignant	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hemiplegia/Nerve injury	<input type="checkbox"/> Other Tumor, metastatic	<input type="checkbox"/> Stress Fractures
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Liver Disorder	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Migraines	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> MRSA Infection	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Gastric Reflux/Peptic Ulcer Disease	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Blood Clots History	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Osteopenia, Osteoporosis	<input type="checkbox"/> Cerebrovascular Disease/Stroke
<input type="checkbox"/> Chron's Disease	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Lupus	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other
<input type="checkbox"/> Concussion	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Seronegative Arthritis	<input type="checkbox"/> No Medical Conditions

Describe or List type of checked selections: _____

Imaging/Test

Have you had any studies/imaging/tests for your problems? Yes ☐ No ☐

If yes, list the date of studies you have had: X-Ray _____ CT Scan _____ MRI _____ Bone Scan _____ EMG/Nerve Study _____
Ultrasound _____ Other _____

Diabetic History: Answer if you have had diabetesHave you ever had a foot ulcer? Yes ☐ No ☐

How long have you been diagnosed with diabetes? _____

Have you lost sight, been on dialysis, neuropathy, or had other medical problems due to diabetes? Yes ☐ No ☐

Who is managing your diabetes? _____

What is your HbA1C level? _____ Date: _____

Past Surgical History for this ProblemHave you had surgery for this problem? Yes ☐ No ☐ Date: _____ Surgeon: _____ Complication (if any): _____

Other Surgical History (Please list all surgeries/hospitalizations you have had) _____

Month/Year of Surgery? _____

I have had no surgeries/hospitalizations in the past ☐**Social/Employment History**Occupation: _____ Currently Working? Yes ☐ No ☐If no, are you a student? Yes ☐ No ☐If no, are you disabled? Yes ☐ No ☐Do you smoke? Yes ☐ No ☐ If yes, how many packs per day? _____ For how many years? _____Do you drink alcohol? Yes ☐ No ☐ How many drinks per week? _____History of substance abuse? Yes ☐ No ☐ If yes, describe _____Relationship Status: Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Do you live: Alone ☐ With others ☐

What do you do for exercise? _____

If you have surgery, do you have people that can assist you/drive you while you are recovering? Yes ☐ No ☐

For Women Only:

Are you or could you be pregnant? Yes ☐ No ☐Have you reached menopause? Yes ☐ No ☐**Family History – Check all the apply**

	Parents	Grandparents	Sibling		Parents	Grandparents	Siblings
Asthma/COPD	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	High Blood Pressure	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Autoimmune Disorder	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Liver Disease	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Bleeding Disorder	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Lupus	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Blood Clots	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Mental Illness	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Bunions	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Osteoarthritis	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Cancer	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Rheumatoid Arthritis	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Diabetes	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Strokes	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Flat feet	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Thyroid Disease	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Heart Disease	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Vascular Disease	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___

Review of Symptoms – Mark all that apply currently or have in the past

General	HEENT	Chest/CV	Derm	GI
___ Weight Loss	___ Ringing in ears	___ Cough	___ Hives	___ Difficulty Swallowing
___ Weight Gain	___ Dizziness/Balance	___ Shortness of breath	___ Rash	___ Heartburn
___ Loss of appetite	___ Fainting	___ Chest Pains	___ Eczema	___ Nausea/Vomiting
___ Chronic Fatigue	___ Vision changes	___ Heart Palpitations	___ Ulcers	___ Chronic abdominal pain
___ Decreased hearing	___ Headaches	___ Leg Swelling	___ Skin Color Change	___ Change in bowel habits
___ Cold Intolerance	___ Nose Bleeds	___ Leg cramping with walking	___ Itching	___ Constipation
	___ Sinus Troubles			___ Diarrhea
	___ Sore Throat			___ Bloody/Tarry stools
	___ Hay Fever/ allergies			
Heme	GU	MSK	Neuro/Psych	
___ Abnormal bruising	___ Urinary Problems	___ Joint Pain	___ Memory Loss	
___ Abnormal bleeding	___ Incontinence	___ Leg Pain	___ Difficulty concentrating	
	___ Urethral discharge	___ Tremors, hand shaking	___ Anxiety	
		___ Muscle weakness	___ Insomnia	
		___ Numbness/tingling	___ Nervousness	
		___ Back pain	___ Depression	
		___ Cold/numb feet		

Patient Signature _____ Date _____

Reviewed By _____ MD Date _____

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.

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: _____



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 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.



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.



BEACON

Orthopaedics & Sports Medicine

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