





## New Patient Background Information – Dr. Justin Kruer

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary reason you are coming into the office today: \_\_\_\_\_

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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? \_\_\_\_\_

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Current Weight \_\_\_\_\_ 1 year ago \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

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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? \_\_\_\_\_



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 as cold or flu)
- Vision loss

**For women only:**

- Extremely painful menstrual cycles
- Irregular cycles      Date of last menstrual cycle \_\_\_\_\_



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:

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## **Pain Management Agreement**

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals. Please initial all the lines on this form.

\_\_\_\_\_ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

\_\_\_\_\_ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

\_\_\_\_\_ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

\_\_\_\_\_ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

\_\_\_\_\_ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems it necessary.

\_\_\_\_\_ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

\_\_\_\_\_ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

\_\_\_\_\_ I will not share my medication with anyone.

\_\_\_\_\_ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

\_\_\_\_\_ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

\_\_\_\_\_ I agree to give Dr. Kruer and his staff 24 hours notice to needing a refill of prescribed medication; and I understand that requests for refills are to be made during regular business hours. No refills of pain medication will be given after hours or on weekends. If I need a refill

prior to the weekend, a request must be made on Thursday. Refill requests must be made by calling the main line at 513-354-3700 or during a scheduled appointment with Dr. Krueger, and cannot be made at the front desk.

\_\_\_\_\_ I agree to use this pharmacy, \_\_\_\_\_, located at this address: \_\_\_\_\_ with the telephone number of \_\_\_\_\_ for filling my prescriptions for all of my pain medicine.

\_\_\_\_\_ I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to give a copy of this Agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

\_\_\_\_\_ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

\_\_\_\_\_ I understand that my provider will be verifying that I am receiving controlled substances from only one provider and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

\_\_\_\_\_ I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

\_\_\_\_\_ I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document was given to me.

This agreement is entered into on this date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

Patient Signature: \_\_\_\_\_

Patient Name (printed): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Provider Name (printed): \_\_\_\_\_

Witnessed by Signature: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_

**Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy**  
Effective April 2009

Patient name: \_\_\_\_\_ Account #: \_\_\_\_\_  
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, 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 changes 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 purposes 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 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.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## 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.*



## 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.

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

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
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)*



## 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