



# INITIAL/ESTABLISHED EVALUATION FORM

ROBERT ROLF, MD

NAME: \_\_\_\_\_

Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

Occupation/Job: \_\_\_\_\_

School: \_\_\_\_\_

Email: \_\_\_\_\_

Will you allow a student to observe your visit?

Yes / No

Who is your Primary Care Doctor:

Did he/she refer you? Yes/No

If no, who is referring you to us?

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Where is your problem? (Please circle)

Shoulder    Knee    Elbow    Hip

Neck    Foot    Back    Ankle    Wrist

Which side(s)?    Right /Left /Both

Location:

Inside    Outside    Deep    Front    Back

Dominant Arm?    Right/ Left

How did you injure yourself?

No injury – just started hurting

Sports (which sport?) \_\_\_\_\_

Motor vehicle accident

Work/job –

Is there a worker's comp claim? Yes / No

Date of Injury? \_\_\_\_\_

How long have you had symptoms?

\_\_\_\_\_ Days    \_\_\_\_\_ Months    \_\_\_\_\_ Years

Please briefly describe the injury:

\_\_\_\_\_  
\_\_\_\_\_

Previous Treatments (other than surgery?)

(Medications, physical therapy, injections, bracing)

\_\_\_\_\_  
\_\_\_\_\_

Previous Surgery for this problem?

\_\_\_\_\_  
\_\_\_\_\_

How severe is the pain (0=none, 10 = severe)

At rest?                    0 1 2 3 4 5 6 7 8 9 10

At its worst?             0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes/ No

Does it awaken you from sleep? Yes/ No

Is it Intermittent (Comes and Goes) or Constant?

Please Circle the following which best describes the nature of your pain (circle all that apply)

Sharp    Dull    Stabbing    Throbbing

Aching    Burning    Other: \_\_\_\_\_

Please circle any associated symptoms you have experienced (circle all that apply):

Swelling    Stiffness    Instability

Giving Way    Numbness    Tingling

Popping    Clicking    Catching    Pain

Other: \_\_\_\_\_

How would you rate your injured joint today as a % of normal (0-100%) with 100% being completely normal? \_\_\_\_\_%

Have you had similar symptoms in the past?

Yes/No

WHEN: \_\_\_\_\_

\_\_\_\_\_

Are you currently working? Yes/ No

Normal job?

Limited duty?

What makes your problem better?

\_\_\_\_\_

What makes your problem worse?

\_\_\_\_\_

Please describe your current limitations(s):

\_\_\_\_\_

Allergies to medication(s)

\_\_\_\_\_

Medical history: (please circle)

Do/did you have heart disease? No / Yes

Do/did you have ulcers/gastritis? No / Yes

Do/did you have diabetes? No / Yes

Do/did you have liver problems? No / Yes

Do/did you smoke? No / Yes









## 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)*

**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: \_\_\_\_\_



# 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





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 CLEVES / 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

## Directions to the Batesville Indiana Office 1360 E. State Road 46 Batesville, IN 47006

### From Cincinnati:

- Take I-74 West, into Indiana
- Take Exit 149, Batesville/Oldenburg
- Turn left on IN 229, .2 miles
- Turn left on IN 46, travel 1.5 miles, Junction 129
- Turn left at the light, office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

### From Lawrenceburg:

- Take US 48 west to IN 129 N to Batesville. At the junction with IN 46 go straight through the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

### From Greensburg/Indianapolis:

- Take I-74 E to exit 149, Batesville/Oldenburg
- Turn right on IN 229 For .2 miles
- Turn left on IN 46, Travel 1.5 miles to Junction with 129
- Turn left at the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

