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 B. Argo, M.D.
John E. Bartsch, M.D.
John J. Brannan, M.D.
Robert R. Burger, M.D.
Peter S. Cha, M.D.
Justin J. Krue, M.D.
Alberto Maldonado, M.D.
Glen A. McClung II, M.D.
Adam G. Miller, M.D.
Allison M. Phelps, M.D.
Robert H. Rolf, M.D.
David Sower, M.D.
Allison M. Phelps, M.D.
Andrew Razzano, M.D.
Ian P. Rodway, M.D.
Michael T. Rohriller, M.D.
Robert H. Rolf, M.D.
David Sower, M.D.
Henry A. Stiene, M.D.
Angel L. Velazquez, M.D.

www.beaconortho.com
Phone: 513.354.3700
Fax: 513.354.3705
Has the injury been treated? Yes ____ No ____ If yes, how has this been treated and by whom? ______________________________________________________

Was this due to an injury? Yes____ No____ Date of Injury ______________________ Did this occur at work? Yes _____ No _____

Note: This is a confidential Record of your medical history and will be maintained in this office. The information contained here will not be released to any person except who you have authorized to do so.

Reviewed By __________________________________________________________ MD  Date ___________________

___Poor Circulation
___Blood Clots ___Hepatitis ___Hay Fever ___Breast Abnormality

Vascular
___Gallbladder Disease ___Ulcer ___Frequent Urination ___Arthritis ___Headaches
___Constipation ___Spasm/Muscle ___Blackouts/Fainting
___Change in Bowel Habits ___Kidney Stones

GI
___Fatigue ___Trauma ___Dizziness ___Heart Attack ___Bronchitis
___Nausea ___Ringing in Ears ___High Blood Pressure ___Lung Disease
___Trouble Sleeping ___Balance Problems ___Irregular Rhythm ___Pneumonia

Hematologic
___Blood Clots ___Hepatitis ___Hay Fever ___Breast Abnormality

Allergy/Immunology
___Poor Circulation
___Anemia ___Dermatitis ___Change in Skin/Hair
___Lymph Node

Pregnancy
___Pregnant: Yes ___ No ___

Drug Allergies:

Latex Allergy? ___________ Yes _____________ No

Name of Primary Care Physician: ________________________________________________________________

Past Medical Problems:

Hospitalizations or Previous Surgeries:

Current Medications: _________________________________________________________________

Latex Allergy? ___________ Yes _____________ No

Drug Allergies: _________________________________________________________________

Name of Primary Care Physician: ________________________________________________________________

Please check if you have ever had a blood transfusion? _____ yes ______ no  If yes give date: ______________________

Do you Smoke? Quit___Yes ____ No____  If yes how many per day? _______ Total years you have smoked?____ Have you ever tried to quit? Y____  N____

Marital Status: S___ M ___ W___ D____ Do you live alone? Yes ___ No ___

Gender: Male: _____ Female_____ Race: ________________   Ethnicity:______________________  Preferred Language: __________________

Do you consume alcohol? Yes ____ No ____ If yes how much per week?___________

Chief Complaint: ______________________________________________________________________________________________________________________

Have you or your family members had any of the following conditions? (Please check all that apply):

Please check if you have ever had the symptom listed – Check all that apply

PLEAS USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions? (Please check all that apply):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self</th>
<th>Mother</th>
<th>Father</th>
<th>Children/Other Relatives</th>
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</thead>
<tbody>
<tr>
<td>Heart Disease</td>
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<td>High Blood Pressure</td>
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<td>Stroke</td>
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<td>Cancer</td>
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<td>Glaucoma</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy/Convulsions</td>
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<td>Bleeding Disorder</td>
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<tr>
<td>Thyroid Disease</td>
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<tr>
<td>Mental Illness</td>
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<td>Osteoporosis</td>
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<td>Tuberculosis</td>
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<tr>
<td>Kidney Disease</td>
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Constitutional

Fever

__ Weight Loss

__ Fatigue

__ Constipation

__ Ulcer

__ Gallbladder Disease

__ Change in Bowel Habits

__ Anemia

__ Diarrhea

__ Constipation

__ Ulcer

__ Change in Bowel Habits

__ Blood Clots

__ Poor Circulation

__ Lymph Node

__ AIDS

Vascular

Hematologic

Allergy/Immunology

Skin/Breast

___ Change in Skin/Hair

Patient Signature ___________________________ Date _______________

Reviewed By ___________________________ MD  Date _______________

Note: This is a confidential Record of your medical history and will be maintained in this office. The information contained here will not be released to any person except who you have authorized to do so.
Patient Name: ___________________________ DOB: ___________________________

Medications List

**Allergies**

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Date</th>
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Please list any medications you are currently taking

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Directions</th>
<th>Reason Taking</th>
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Preferred Pharmacy: ___________________________ Date: ___________________________
Location/Number: ___________________________
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.

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

<table>
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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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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 cashier’s 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:________________________
Driving Directions to Beacon Orthopaedics
Miamisburg Location
2835 Miami Village Drive
Miamisburg, Ohio 45342
513-354-3700

From I-75 North
Head north on I-75
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township
Use the right 2 lanes to turn right onto Austin Blvd
Use the left 2 lanes to turn slightly left toward OH-741 N
Use any lane to turn left at the 1st cross street onto OH-741 N
Turn right onto Miami Village Drive
The Beacon Location will be on your left

From I-75 South
Head south on I-75
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township
Use the left 2 lanes to turn left onto Austin Blvd
Use the left 2 lanes to turn slightly left toward OH-741 N
Use any lane to turn left at the 1st cross street onto OH-741 N
Turn right onto Miami Village Drive
The Beacon Location will be on your left

From I-675 South
Head west on I-675 S
Use the left 2 lanes to merge onto I-75 S toward Cincinnati
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township
Use the left 2 lanes to turn left onto Austin Blvd
Use the left 2 lanes to turn slightly left toward OH-741 N
Use any lane to turn left at the 1st cross street onto OH-741 N
Turn right onto Miami Village Drive
The Beacon Location will be on your left
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.