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.

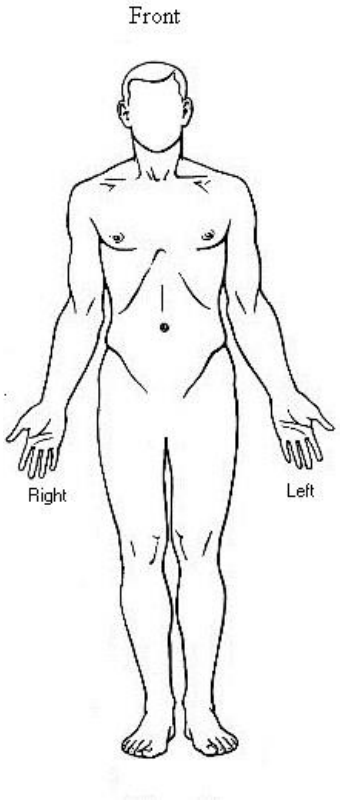
We look forward to serving you.

Patient Intake Form
Revised 6/12/2019

Name:_____ Pharmacy Name:_____
Birthday:_____ Age:_____ Pharmacy Location:_____
Height:_____ Weight:_____ Primary Care Physician:_____
Occupation:_____ Referring Physician:_____

History of Present Illness:

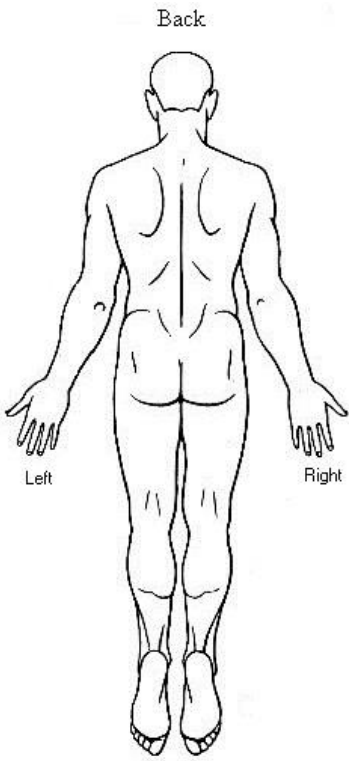
What is the primary reason for your visit today?_____



Please draw the location of your primary complaint for today's visit:

1. Mark **PAIN** with: **XXX**
(aching, burning, stabbing, cramping, etc…)

2. Mark **ALTERED SENSATION** with: **OOO**
(pins, needles, numbness, decreased sensation, etc…)



How did the problem start? □ Gradually □ Suddenly (Date:_____

Please Describe:_____

_____

What INCREASES the pain?

□ Night/Sleep □ Sit to stand transition
□ Activity □ Walking
□ Bending Forward □ Sitting
□ Bending Backward □ Standing

What DECREASES the pain?

□ Nothing □ Medication
□ Changing Positions □ Lying Down
□ Bending Forward □ Sitting
□ Bending Backward □ Standing

What treatments have you had for this problem?

□ Nothing □ Chiropractic □ Acupuncture □ Physical Therarpy
□ Medications
□ Anti-Inflammatories (aspirin, ibuprofen, naproxen, Celebrex, Mobic etc…)
□ Oral Steroids □ Muscle Relaxants □ Opiates / Narcotics
□ Other:_____
□ Injections
□ Epidural □ Facet Joint □ Sacroiliac Joint □ Nerve Block □ Ablation/Rhizotomy
□ Other:_____

Patient Intake Form
Revised 6/12/2019

BEACON Orthopaedics & Sports Medicine SPINE

Medical History (please check all that apply)

□ Anesthesia Problem
□ Anemia
□ Atrial Fibrillation
□ Coronary Artery Disease
□ Myocardial Infarction
□ Bleeding Disorder
□ DVT (Blood Clot)
□ Pulmonary Embolism
□ Stroke (CVA)
□ High Cholesterol
□ Hepatitis C
□ HIV/AIDS
□ Liver Disease
□ Kidney Disease
□ Thyroid Disease
□ Hypertension
□ Sleep Apnea
□ Asthma
□ COPD
□ Tuberculosis
□ Arthritis(rheumatoid)
□ Arthritis(osteo)
□ Osteopenia / Osteoporosis
□ Benign Prostatic Hypertrophy
□ ADD/ADHD
□ Anxiety
□ Depression
□ Alcoholism
□ Substance Abuse
Other:_____
□ Chronic Pain
□ Fibromyalgia
□ Migraine Headaches
□ Seizure Disorder
□ Parkinson's
□ Diabetes
□ GERD
□ Stomach/Duodenal Ulcer
□ Cancer (Type_____)
Other:_____

Surgical History (please check all that apply)

□ Angioplasty
□ Appendectomy
□ Bowel Resection
□ Cardiac Stents
□ Coronary Artery Bypass
□ Defibrillator
□ Pacemaker
□ Carpal Tunnel Release
□ Cataract
□ Gall Bladder Surgery
□ Gastric Bypass
□ Hernia Repair
□ Hysterectomy
□ C-Section
□ Joint Replacement (Hip/Knee/Shoulder)
□ Other:_____
□ Arthroscopic Surgery (Joint:_____)
□ Mastectomy
□ Thyroidectomy
Other:_____
Other:_____

Current Medications: _____

_____

_____

_____

Allergies:

Allergen:	Reaction:	Allergen:	Reaction:	Allergen:	Reaction:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History:

	Mother	Father	Sibling	Grandparents
Anesthesia Complication	□	□	□	□
Bleeding Disorder	□	□	□	□
Cancer	□	□	□	□
Depression	□	□	□	□
Diabetes	□	□	□	□
Heart Disease	□	□	□	□
Hypertension	□	□	□	□
High Cholesterol	□	□	□	□
Osteoarthritis	□	□	□	□
Scoliosis	□	□	□	□
Spine Disorder	□	□	□	□
Stroke	□	□	□	□

For Women:
Currently Pregnant?
□ Yes □ No
Last Menstrual Period:_____

Other significant medical problems of which we should be aware?

_____

_____

_____

_____

BEACON Orthopaedics & Sports Medicine SPINE

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widowed

Highest Level of Education Attained:_____

Employment Status:

□ Full Time □ Disabled □ Student
□ Part Time □ Unemployed □ Retired

Occupation:_____ If unemployed, last time you worked:_____

Do you use tobacco or nicotine products? □ Yes □ No How much & What type:_____
Do you drink alcohol? □ Yes □ No How much & What type:_____
Do you exercise? □ Yes □ No How much & What type:_____

Review of Systems:

(Please check if you **CURRENTLY** have any of the following symptoms)

Constitutional
□ Fever
□ Chills
□ Night Sweats
□ Fatigue
□ Weight Loss

Eyes/Ears/Nose/Throat
□ Double Vision
□ Blurry Vision
□ Hearing Loss
□ Ringing in Ears
□ Dizziness
□ Balance Problems
□ Sinusitis

Psychological
□ Anxiety
□ Depression
□ Sleep Disorder
□ Memory Problems
□ Mood Swings

Cardiac/Vascular
□ Chest Pain
□ Racing Heart Beats
□ Skipping Heart Beats
□ High Blood Pressure
□ Heart Murmur
□ Blood Clots
□ Poor Circulation

Respiratory
□ Shortness of Breath
□ Asthma
□ Lung Disease
□ Bronchitis
□ Pneumonia
□ Sleep Apnea

Gastrointestinal
□ Diarrhea
□ Constipation
□ Ulcer
□ Heartburn

Neurological
□ Headaches
□ Confusion
□ Loss of balance
□ Tingling
□ Tremmors
□ Numbness

Genitourinary
□ Leaking Urine
□ Prostate Disease
□ Pain with Urination
□ Frequent Urination
□ Kidney Stones

Skin/Breast
□ Rash
□ Sores
□ Wounds
□ Change in Skin/Hair
□ Breast Abnormality
□ Easy Bruising

Musculosceletal
□ Fracture
□ Arm Pain
□ Leg Pain
□ Back Pain
□ Neck Pain
□ Joint Pain
□ Swelling
□ Stiffness
□ Atrophy
□ Arthritis
□ Muscle Spasm
□ Gout

Allergy/Immunology
□ Hay Fever
□ Dermatitis

Hematologic
□ Hepatitis
□ HIV/AIDS
□ Anemia

I have filled out this form truthfully and to the best of my ability.

Patient Signature:_____ Date:_____

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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: _____

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: _____

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

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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.

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Orthopaedics & Sports Medicine

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.

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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