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.

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# INITIAL/ESTABLISHED EVALUATION FORM

ROBERT ROLF, MD

**Date:**_____

**Name:**_____ **Date of Birth:**_____
**Age:**_____ **Gender:** ❑ Female ❑ Male **Email:**_____
**Ethnicity:** ❑ African American ❑ Caucasian ❑ Hispanic ❑ Asian ❑ Other_____
**Height:**_____ **Weight:**_____ **Hand Dominance:** ❑ Right ❑ Left ❑ Ambidextrous
**Occupation/Job:**_____
**School:**_____(if you are a current student)
**Primary Care Physician**:_____ **Did he/she refer you?** ❑ Yes ❑ No
*If no, how did you hear about us*?_____
**Have you been evaluated by a physician for this condition?** ❑ No ❑ Yes:_____
**Did you go to Urgent Care or Emergency Department for this condition?** ❑ No ❑ Yes:_____
**Have you had a previous surgery for this condition?** ❑ No ❑ Yes:_____
**Will you allow a student to observe your visit?** ❑ No ❑ Yes

**What body part is bothering you?** **Which side(s)?** ❑ Right ❑ Left ❑ Both
❑ Neck ❑ Shoulder ❑ Elbow ❑ Wrist/Hand ❑ Back ❑ Hip ❑ Knee ❑ Ankle ❑ Foot

**Location:** ❑ Inside ❑ Outside ❑ Deep ❑ Superficial ❑ Front ❑ Back ❑ Top ❑ Bottom

**When did your problem begin?** ❑ Days:_____ ❑ Months:_____ ❑ Years:_____ ❑ Date:_____
❑ No Injury ❑ Sport ❑ Motor Vehicle Accident ❑ Work ❑ Worker's Comp Claim
❑ Briefly Describe Injury_____

**Treatment Attempted?** ❑ None ❑ Ice ❑ Heat ❑ Rest ❑ Elevation ❑ Brace/Splint ❑ Crutches
❑ Medication:_____ ❑ Physical Therapy ❑ Home Exercise Program

**What is your severity? (0 normal, 10 extreme)**
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

❑ Night Pain ❑ Awakens from Sleep ❑ Difficulty Falling Asleep ❑ Limits Activities of Daily Living
❑ Limits Work

**If 100% is completely normal, how would you rate your injured body part?**
100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

**Describe your pain:** ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning ❑ Shooting
❑ Constant ❑ Comes and Goes ❑ None

**Associated Symptoms:** ❑ Swelling ❑ Stiffness ❑ Instability ❑ Giving Way ❑ Numbness ❑ Tingling
❑ Popping ❑ Clicking ❑ Catching/Locking ❑ Bruising ❑ Grinding ❑ Decreased Motion ❑ Limping
❑ Spasm ❑ Weakness ❑ Radiating_____ ❑ None

**What makes your pain/symptoms worse?** ❑ Bending ❑ Up Stairs ❑ Down Stairs ❑ Lifting ❑ Movement
❑ Pushing ❑ Pulling ❑ Sitting ❑ Standing ❑ Walking ❑ Running ❑ Sleeping ❑ Squatting ❑ Kneeling
❑ Nothing

**What makes your pain/symptoms better?** ❑ Ice ❑ Heat ❑ Rest ❑ Elevation ❑ Brace/Splint ❑ Crutches
❑ Medication:_____ ❑ Exercise ❑ Stretching ❑ Movement ❑ Nothing

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# Patient History Form for Dr. Robert Rolf

**Patient Name (print):** _____ **Date of Birth:** _____
**Gender:** □ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed
**Race:** _____ **Ethnicity:** _____ **Preferred Language:** _____
**Referred to Dr. Rolf** □ Self □ Family □ Physician □ Attorney □ Other: _____
**Name of Person(s) making referral**: _____

## PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE EVER HAD:
## OR
## ☐ PLEASE CHECK IF NONE APPLY TO YOU:

**Constitutional:**
Fever
Weight loss
Fatigue
Weakness
Dizziness

**Gastro-Intestinal:**
Ulcer
Frequent heartburn
Reflux
GI Bleeding

**Urinary:**
Prostate problems
Kidney Stones
Chronic infections
Frequent urination

**Cardiovascular:**
Chest Pain or angina
Shortness of breath
Heart murmur
Heart attack
Irregular heartbeat
Fainting or syncope
Ankle swelling
Rheumatic fever

**Surgical:**
Anesthesia problems
Wound healing problems

**Psychological:**
Depression
Anxiety disorder
Memory problems

**Respiratory:**
Asthma
COPD
Lung disease
Pneumonia
Tuberculosis

**Hematologic:**
Anemia
Poor Circulation
Phlebitis
Blood clots
Excessive bleeding
Blood transfusion

**Allergy/Immune:**
Seasonal Allergies
Skin conditions

**Musculoskeletal:**
Joint pain
Joint swelling
Muscle weakness
Muscle tenderness
Muscle spasms
Morning stiffness
Rheumatoid arthritis
Osteoporosis
Gout

**Neurological and ENT;**
Seizures or epilepsy
Stroke or TIA
Headaches
Trembling or Tremor
Balance problems
Hearing or vision loss

## PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE OR HAVE BEEN TREATED FOR:
OR
## ☐ PLEASE CHECK IF NONE APPLY TO YOU:

AIDS/HIV
Alcoholism
Alzheimer's
Anemia
Asthma
Blood Clots
COPD
Colon Cancer
Lung Cancer
Breast Cancer
Prostate Cancer
Cancer (type) _____
Depression
Diabetes
Drug Abuse
Gout
Heart Disease
Hypertension
Hepatitis
Kidney Disease
Osteoarthritis
Seizures
Ulcers
Osteopenia or Osteoporosis

**Please list any other medical conditions we should be aware of:** _____
_____
_____

**Who is your Medical Doctor?** _____
**What is your current height?**_____ **What is your current weight?**_____
**Do you have any allergies to medication?** □ Yes □ No **If yes, list medication(s) and reaction:** _____
**List any previous surgeries or overnight hospital stays (Please include year**):_____
_____
_____

**CONTINUE ON 2ND PAGE**

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**PLEASE CIRCLE THE FOLLOWING CONDITIONS YOUR IMMEDIATE FAMILY (MOTHER, FATHER OR SIBLINGS) HAVE BEEN TREATED FOR:**

| | | | |
|---|---|---|---|
| AIDS/HIV | COPD | Depression | Hepatitis |
| Alcoholism | Colon Cancer | Diabetes | Kidney Disease |
| Alzheimer's | Lung Cancer | Drug Abuse | Osteoarthritis |
| Anemia | Breast Cancer | Gout | Seizures |
| Asthma | Prostate Cancer | Heart Disease | Ulcers |
| Blood Clots | Cancer (type) _____ | Hypertension | Osteopenia or Osteoporosis |

List any other conditions:_____

**Which hand do you write with?** □ Right □ Left **Are you retired?** □Yes □ No
**What is your occupation or job title?** _____
**Are you currently employed?** □ Yes □ No **Who is your employer?** _____
**Circle the best description of your previous education (circle one**):
Graduate School College graduate Some college HS Graduate GED Technical Training
**Do you use tobacco?** □ Yes □ No □ Former **If yes, which type?** Chewing Cigar Cigarettes Pipe
**Please list amount and duration: (example 1 pack a day for 20 years**)_____
**Do you consume alcohol?** □ Yes □ No □ Former: **Do you consume caffeine ?** □ Yes □ No
**Please list amount and duration: (example 2 sodas a day or alcohol socially**)_____
**How would you describe your activity level?** (Circle one): Above average Average Sedentary
**How frequently do you exercise?** (Circle one)
2-3 times/week 3-4 times/week 5 times/week Daily Never Occasionally
**Which physical activities or sports are you involved with?**_____
**Please list your hobbies or activities:** _____

**Please list any additional information which you think we might need to know to provide you with the best care possible:**_____

**Patient signature:**_____ **Date:**_____

**Physician signature:**_____

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Patient Name: _____ DOB: _____

**Medications List**

**Allergies**

_____ _____

_____ _____

Please list any medications you are currently taking

| Drug Name | Dosage | Directions | Reason Taking |
|---|---|---|---|
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Preferred Pharmacy:_____ Date:_____

Location/Number:_____

PATIENT NAME: _____

DOB:_____

PAIN MEDICATION POLICY
DR. ROBERT ROLF

The purpose of this agreement is to prevent any misunderstanding about the distribution of medications from Dr. Robert Rolf. Please initial each line on this form and sign at the bottom.

_____ As an Othopaedic Surgeon and Sports Medicine Physician, Dr. Rolf is responsible for diagnosis and treatment of immediate orthopaedic related pain and complications.

_____ As such, Dr. Rolf does NOT prescribe long-term medication prescriptions to his patients.

_____ Any long-term medication use, be it narcotic, non-narcotic, or anti-inflammatory, must be obtained through a Primary Care Physician, or other designated provider.

_____ In the event surgical intervention is performed, Dr. Rolf will ONLY prescribe narcotic pain medication for up to 2 prescriptions post-operatively, dependent upon the procedure.

_____ Dr. Rolf may prescribe pain medication for severe or complicated fractures.

_____ As the patient, please understand medication provided should not be used at a more accelerated rate than originally prescribed, as this may result in being without medication for a period of time should violations occur.

_____ I understand that with the use of prescription monitoring software, Dr. Rolf may verify if pain medication is being administered by any other source while being prescribed by Dr. Rolf.

____ I agree refills of prescriptions must be requested during regular office hours. No refills will be given after hours or on weekends.

_____ If a medication will need to be refilled over the weekend, please request the prescription by Thursday.

_____ We request at least 24-hour notice for all refill authorizations, so as to ensure arrangements can be made.

I, _____ understand these guidelines as described above and agree to follow the policy outlined in this document.

_____ _____

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.**

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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/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: _____

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**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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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:**

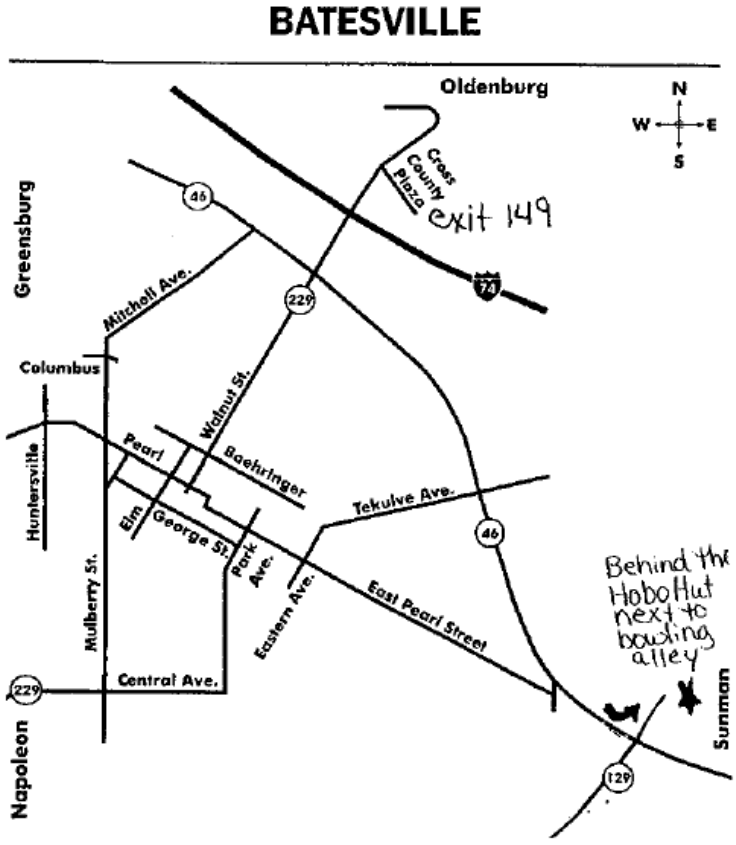
- Take I-74 West, into Indiana
- Take Exit 149,Batesville/Oldenburg
- Turn left on IN 229, .2 miles
- Turn left on IN 46, travel 1.5 miles, Junction 129
- Turn left at the light, office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

**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

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