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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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:_____

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# New Patient Background Information – Dr. Brian Braithwaite

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? _____

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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 and cold or flu)

____ Vision loss

**For women only:**

_____ Extremely painful menstrual cycles

____ Irregular cycles Date of last menstrual cycle _____

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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. Braithwaite 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. Braithwaite, 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): _____

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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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# 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