

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.



New Patient Background Information – Dr. Justin Kruer

Name: _____

Date of Birth: _____

Primary reason you are coming into the office today: _____

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) _____



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? _____

Current Weight _____ 1 year ago _____ Height: _____ BP: _____

Gender: _____ Race: _____ Marital Status: _____

Occupation: _____

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? _____



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 as cold or flu)
- Vision loss

For women only:

- Extremely painful menstrual cycles
- Irregular cycles Date of last menstrual cycle _____



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:

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____



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
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/Representative Signature: _____ Date: _____

<i>If patient is a minor</i> , 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: _____