

100 Navarre Place Suite 4440 South Bend, IN 46601 574-647-5300

Date:
Dear,
We are looking forward to seeing you at your first appointment with
Bone & Joint Specialists-Navarre. Please bring the completed enclosed paperwork along with your most current insurance card and photo ID. Please remember that your copayment, coinsurance and out of pocket responsibilities are due at time of service. If uninsured, please be prepared to pay minimum of \$125 toward the current office visit.
Your account with Beacon medical Group shows a current balance of
\$ and a collections balance of \$ Please
come prepared to make payment on your account. We accept check, cash, or credit. If you have a Health Savings Account (HSA) that you would like to use,
please bring your HSA card for payment. If you have any questions or need to
make payment arrangement, please contact our billing department at 888-449-
7776 or 574-647-1610.
Thank you for choosing Beacon Medical Group to meet your health care needs.



## PATIENT REGISTRATION - ADULT

Date:					
First Name:	MI:	Last Name:			
Preferred First Name:					
Address:	City:	State: _	Zip:		
Secondary Address:	City:	State:	Zip:		
Primary Phone:	Secondary Phone:	Work:			
SS #:	Sex: M F Email:				
Marital Status: ☐ Married ☐ Sing	gle □ Divorced □ Wido	wed Dther	2		
Preferred Language: Fnglish		DEronah Do			
Race:   Asian   Native Hawaiian/Other Pacific Islander   Black/African-American  American Indian/Alaskan Native   White/Caucasian   More than 1 race					
Ethnicity:	☐ Hispanic/Latino	☐ Declined/other			
Patient Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Other					
Name of Patient Employer (i	f applicable):				
INSURANCE POLICY HOLDER INF	ORMATION				
First Name:	MI: L	ast Name:			
Date of Birth://	Relationship	to Patient:			
Address:	City:	State:	Zin:		
SS #:	Employer: _				



# RELEASE OF VERBAL MEDICAL INFORMATION

B. (1 ).						
Patient Name:	Date of Birth: /					
The purpose of the Release of Verbal Medical Inforpermit verbal release of Protected Health Information authorize release of copies of medical records):	mation forms is to provide our patients an opportunity to on (PHI) in the following two (2) ways (this does not					
1. Permission to verbally discuss PHI with family I hereby authorize medical providers and personnal health information with the following person(s):	y members/caregivers nel of Beacon Health System to discuss my protected					
Name:	Emergency contact:					
Primary Phone:						
Name:						
Primary Phone:						
(OR) I decline. Please do not discuss my care	with anyone other than as allowed by HIPAA regulations.					
voiceman or answering machine messages at voin	nts. By circling YES, Beacon Health System will leave r home, work or emergency contact on file that may may be overheard by others not involved in your care.					
Place Callback /	Message Detailed Message					
Home Yes /	/ No Yes / No					
Work Yes /	No Yes / No					
Emergency Contact Yes /						
This authorization applies to all Beacon Health System providers. This authorization will remain in effect until revoked or changed. I understand that such revocation is not effective to the extent that the clinic has relied on the use of disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and my no longer be protected by state or federal law. This form is not valid unless signed and dated.						
Signature of Patient/Personal Representative	Printed Name of Patient/Personal Representative					
Date	Relationship to the Patient					



### CONSENT FOR TREATMENT

Patient Name:	DOB:		1
CONSENT FOR TREATMENT: I request and voluntarily give consent to the Beacon Medical Group System and Beacon Medical Group agents, employees, independent contractors, medical residents Beacon providers to provide treatment, consultation and/or other services and supplies as are consider or healthcare provider for my health and well-being. I understand that services may include medical diagnostic tests deemed appropriate by physicians or other healthcare providers. I am aware that the an exact science and I acknowledge that no guarantees have been made to me as to the results of constants.	and students un dered advisable l treatment, x-rays	der the di by my phy , blood te	irection of the ysician ests, and other

- 2. RELEASE OF INFORMATION FOR PAYMENT OF SERVICES AND CONTINUITY OF CARE: I understand that Beacon Health System and my providers may release any and all information regarding my diagnosis, treatment and prognosis with respect to any physical or mental health condition (including treatment for alcohol and/or drug abuse) for which I am being treated at any Beacon Health System facility or by Beacon Medical Group, to any insurance company, employer, sponsored payer and/or third party payers providing coverage for my treatment and care. Information will also be released to other health care providers for continuity of care and/or to my designated legal representative. I understand that state and federal laws may require Beacon Health System and its providers to release my personal health information to law enforcement agencies for mandatory reporting of certain crimes and/or suspected abuse or neglect, and for the control of communicable diseases.
- 3. ASSIGNMENT OF BENEFITS: I hereby assign Beacon Health System all insurance benefits covering my care and treatment. If I am a Medicare or Medicaid beneficiary, I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Beacon Health System for services furnished to me by a Beacon Health System facility or Beacon Medical Group providers, including physician services. I authorize Beacon Health System to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand that regardless of this assignment of insurance benefits, I remain responsible to Beacon Health System for all charges related to my treatment and healthcare services provided for me. It is further agreed that any self-pay credit balance resulting from payment of the insurance benefits may be applied to any other account owed to Beacon Health System by me or my family. I authorize the use of this signature for all my insurance submissions made by Beacon Health System for my care and treatment.
- 4. FINANCIAL AGREEMENT: I will make every effort to assist Beacon Health System with securing payment for services rendered for which I am financially responsible. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third party payer agreements, I am financially responsible for all services rendered, and that the parent/guardian who authorizes treatment will be responsible for any balance due. I understand that Beacon Health System submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I voluntarily consent for Beacon Health System to serve as my authorized representative to assist in the appeal of insurance coverage for my health care or the health care of my dependent. I authorize that all information from any insurance appeals may be provided directly to Beacon Health System. I understand that my third party payer (insurer) may require me to obtain authorization in order for services to be covered. I understand that if I do not provide sufficient and timely information and/or releases of information for Beacon Health System to process insurance claims, I will be responsible to pay Beacon Health System full and standard fees. I agree to pay any collection costs and/or legal fees incurred by Beacon Health System in attempts to collect the balance owed on my account.
- 5. OUTSIDE SERVICE PROVIDERS: I understand that provider charges and professional fees for the interpretation of diagnostic tests and certain other services may be billed separately. I give consent for Beacon Health System to provide insurance information to outside service providers so that they can bill for services. I understand that if I receive any provider's services or other services that are billed separately that this consent will serve as a release of information and assignment of benefits for these providers, and payment is to be made directly to them or their billing agent.
- 6. WRITTEN NOTICE OF POTENTIAL OUT-OF-NETWORK CHARGES: From time to time, Beacon Medical Group may refer you to a different provider for more specialized care and/or testing. It is up to you to evaluate whether the provider you are being referred to for specialized care and/or testing is part of your insurance network (in-network) BEFORE your visit. In addition, some providers at Beacon Health System may not be in your insurance network.

Most insurance plans have a phone number that patients can call to verify whether the provider they are being referred to is "in-network" or "out-of-network" and to provide other assistance. Insurance providers can also furnish a list of "in-network" providers that may provide the specialized care and/or testing required.

If your insurance confirms the provider you are being referred to is "in-network," this means your insurance plan has negotiated a rate with this provider and all or part of the cost should be paid by your insurance. Each insurance plan is different, so for detailed information, please contact your insurance provider.

If your insurance confirms the provider you are being referred to is "out-of-network," this means there is potential to have a greater out-of-pocket cost for care from this provider. This is because an out-of-network provider is not bound by the payment terms of your health plan. It will be up to you to decide whether you want to visit this provider or work with the referring provider and your insurace to find an "in-network" provider.

Patient Name: \_\_\_\_\_



- 7. PHOTOGRAPHY: I consent to have my photograph taken and used for identification during my treatment and maintained in my medical record. Photographs without identifying information may be used internally by Beacon Health System for educational purposes.
- 8. NOTICE OF COMMUNICATION PRACTICES: I consent to receiving auto-dialed calls and/or artificial or prerecorded voice message calls to my cellular and/or landline telephones from Beacon Health System, its providers, and/or its agents for any permissible purpose, including, but not limited to, healthcare and business administration and operations.
- 9. **OBTAINING HEALTH-RELATED INFORMATION:** I authorize Beacon Health System to obtain my health and prescription information from electronic sources, such as SureScripts, or other appropriate sources which might be available.
- 10. HEALTH INFORMATION EXCHANGE: I understand that Beacon Health System participates in Health Information Exchanges (HIEs) to allow healthcare providers to share information for the purpose of coordinating patient treatment and services. I may choose to OPT OUT of electronically sharing my health information through any Health Information Exchanges for any reason.
  - I elect **NOT TO PARTICIPATE** in the Health Information Exchanges at this time (OPT OUT). I understand by opting out, my current or future medical information from Beacon Health System will not be shared with the HIEs. If I want to participate in the HIEs in the future (OPT IN), I will contact the Beacon Privacy Officer.
- 11. INDEPENDENT CONTRACTORS: I understand that some of the providers at Beacon Health System are not employees and are instead independent contractors who have been granted the privilege of using Beacon Health System facilities for the care and treatment of their patients, and that Beacon Health System is not liable for the acts of these independent contractors.
- 12. GOVERNING LAW AND VENUE: I understand that any claim or dispute arising from or related to the treatment or services I receive will be determined according to applicable state law, depending on clinic location, and I agree that the venue for any lawsuit will be in the county of service.

Your signature below indicates that you have received this information, consent to treatment, and understand your financial obligations and options.

# I ACCEPT THE TERMS LISTED ON THIS DOCUMENT AND CERTIFY THAT A COPY OF THIS DOCUMENT HAS BEEN MADE AVAILABLE TO ME UPON MY REQUEST. I certify that I am the patient or am legally authorized to sign for the patient.

OR	LEGALLY AUTHORIZED REPRESENTATIVE	DATE	TIME
OR	LEGALLY AUTHORIZED REPRESENTATIVE	RELATIONSHIP	TO THE PATIENT
		DATE	TIME
	277.10		OR LEGALLY AUTHORIZED REPRESENTATIVE RELATIONSHIP



## **Acknowledgement of Receipt of Notice of Privacy Practices**

I have been presented with and received the Notice of Privacy Practices for Beacon Medical Group which provides a complete description of health information uses and disclosures. I understand that this Notice of Privacy Practices may change over time and that the obligations of the Beacon Medical Group and my rights under it may change. Name of Patient Patient Date of Birth (\*required) Signature of Patient Date / Time Guardian of Patient Signature of Guardian Date / Time Witness Signature of Witness Date / Time For Office Use Only Acknowledgment of receipt of Notice of Privacy Practices was not obtained, despite Beacon Medical Group's good faith efforts because: Individual refused to sign Communication barriers prohibited obtaining the acknowledgement Patient unable to sign □ Other (please specify): Acknowledgement not documented: ■ Notice of Privacy Practices was mailed to patient on: \_\_\_\_\_ Witness Signature of Witness Date / Time



## **ORTHOPAEDICS & SPORTS SPECIALISTS**

Name:	DOB:	
Is Your Condition or Injury Related to Work?	Yes	No
Is Your Condition or Injury Related to an Auto Accident?	Yes	No
Is Your Condition or Injury Related to a Fall on Someone Else's Property?	Yes	No
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUEST OUR OFFICE WITH WORKERS COMPENSATION, AUTO LIA INSURANCE INFORMATION, PLEASE RETURN TO THE FR	ABILITY OR COMMERCIAL LIA	PROVIDED ABILITY
Check One:		
I agree that the condition and/or injury for which I am so Not the result of my employment, an auto accident or fall.	eeking evaluation and treatm /injury on someone else's pro	nent <u>IS</u> operty.
I agree that the condition and/or injury for which I am see The result of my employment, and auto accident or fall/injude have provided BOSS with claim information and/or am page 1	jury on someone else's prope	erty AND I
Patient Signature	Date	

NAME:	Primary Care Doctor:
Height:ft	in.
Weight: lbs.	
Dominant Hand: Right L	eft
Race: Caucasian Africa	n American Native American Asian Other:
<b>Ethnicity:</b> Not His	spanic or Latino Identity Latino or Hispanic Identity
Preferred Language: English	Spanish Other:
Are You Pregnant: Yes	No
Alchol Use: Daily	Occasionally Never
Tobacco Use: Every day	Some Days Former Smoker Never Smoked
Do You Have A Cardiologist?	Yes No
If so, List Name:	
Do You Have A Pain Specialist:	Yes No
If so, List Name:	
Current Pain (1-10):	
Do You Have A Pacemaker?	Yes No
Do You Take Blood Thinners?	Yes No
Are You Allergic To:	
Latex?	Yes No
Iodine?	Yes No
Contrast Dye?	Yes No

CURRENT MEDICATIONS	ALLERGIES	PRIOR SURGERY/YEAR DONE
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
*If you have a list prepared, we will make a copy.		

PERSONAL HIST	ORY			FAMI	LYI	HIST	TORY		Posterior	
AIDS/HIV	YES	S NO		Check the box under family member having the condition						
Alcoholism	Yes	NO					Mother	Father	Sit	oling's
Alzheimer's	Yes	NO		Alcoholism					T	
Anxiety	Yes	NO		Alzheimer's					$\top$	
Arthritis	Yes	NO		Asthma					$\top$	
Asthma	Yes	NO		Cancer					$\top$	
Blood Clots	Yes	NO		CVA (Stroke)					$\top$	
Blood Disorder	Yes	NO		Diabetes					T	
Cancer	Yes	NO		Heart Disease					T	
Cysts	Yes	NO		High Cholesterol						
Chronic Pain	Yes	NO	AND SHE	High Blood Pressure						
COPD	Yes	NO	THE PARTY OF	Osteoaarthritis						
Depression	Yes	NO		Problem With Anesthe	sia					
Diabetes	Yes	NO		Rheumatoid						
Emphysema	Yes	NO		Seizures						
Gout	Yes	NO		Thyroid Disorder						
Hearing Loss	Yes	NO								
Headaches	Yes	NO		ARE YOU HAVIN	IG A	NY (	OF THE FOLLO	WING?		NI-SHITTINI
Heart Failure	Yes	NO		Constitutional			Immunologic			
Heart Attack	Yes	NO		Chills	Y	N	Asthma		Y	N
High Blood Pressure	Yes	NO		Fever	Y	N	Seasonal Allerg	gies	Y	N
High Cholesterol	Yes	NO		Weakness	Y	N	Hay Fever		Y	N
Irregular Heart Rate	Yes	NO		Respiratory Musculoskeletal			-			
Osteoarthritis	Yes	NO		Cough	Y	N	Joint Pain		Y	N
Osteoporosis	Yes	NO	H	Known TB Exposure	Y	N	Joint Stiffness		Y	N
Parkinson's	Yes	NO	I	Recent Infection	Y	N	Joint Swelling		Y	N
Raynaud's Disease	Yes	NO		Cardiovascular			Integumentar	у		
Rheumatoid Arthritis	Yes	NO		Chest Pain	Y	N	Skin Infections		Y	N
Seizures	Yes	NO	F	Heart Murmur	Y	N	Skin Lesions		Y	N
Stroke	Yes	NO	I	rregular Heartbeat	Y	N	Skin Rash		Y	N
Thyroid Disorder	Yes	NO		Hema/Lymph Neurologic						
Ulcers	Yes	NO	E			Y	N			
Additional Concerns:	2-1111		E	Bruising Easily	Y	N	Numbness		Y	N
			- Marie	Cuts Slow to Heal	Y	N	Poor Coordinati	on	Y	N
			Endocrine Psychiatric							
			1000000	Cold Intolerance Diabetes	Y	N	Anxiety		Y	N
			-	Thyroid Problems	Y	N N	Depression Insomnia	,	Y	N N
	-		1	ngrote i rootellis	1	14	moonina		I	14

#### **BOSS Pain Management Policy**

The BOSS team is committed to responsibly managing your post-operative plan. In light of the national opioid crisis, it is within current best practices to use a multi-modal pain regimen. This entails a combination of pain medications (narcotic and non-narcotic) with a focused goal of stopping narcotics for pain control in a timely fashion consistent with the expected and usual duration of need (<1-2wks for minor surgery and <3-4wks for major surgery). Prolonged narcotic use is clearly documented to have many negative consequences; this includes narcotic dependency/addiction, mood changes, altered concentration, constipation, urinary retention, sexual dysfunction and preventing fractures from healing. These negative effects occur within the first week or two of starting narcotics as your body's natural response to this class of medication; some people are more prone to these effects than others.

#### What to expect?

- Your pain will be managed with different medications which require your responsible use.
- You should expect some pain from your injury or surgery even with medications.
- We care about your pain but also want to prevent addiction problems.
- You will receive a prescription for FDA restricted pain medications covering one week at a time after surgery (as dictated by most insurance companies). Refills for these restricted medications should be requested in a timely fashion and must be picked up in person from our office during regular business hours (Monday-Friday 8am-4pm). By law, we cannot refill pain prescriptions after hours or on the weekends
- Together we will wean you appropriately from narcotics and rely on long-term pain management With Tylenol and Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) (i.e. Naprosyn).

#### What medications are used?

- Acetaminophen/Tylenol 650mg Extra Strength taken 4 times daily to prevent pain. Prolonged daily use can negatively affect liver functions.
- Naproxen/Naprosyn (anti-inflammatory) 500mg or Celecoxib/Celebrex 200mg twice daily or Ibuprofen 600mg three times daily to prevent pain and swelling. Prolonged use can negatively affect the stomach and any daily use over 30 days should be accompanied by a protective medicine for the stomach (i.e. Pepcid 40mg once or twice daily when taking NSAIDS.
- Gabapentin/Neurontin (non-narcotic nerve medication) may be prescribed three times daily To prevent or control nerve pain. Higher doses (>600mg/dose) should be weaned before stopping.
- Tramadol 50mg (narcotic equivalent) taken <u>as needed for moderate pain</u> every 6 hours. **Not to be** taken unless the pain is not relieved from Tylenol. Naproxen/Celebrex and/or Gabapentin.
- Hydrocodone 5mg with acetaminophen 325mg (Norco) or Oxycodone 5 mg immediate release (narcotics) should be taken as needed for several breakthrough pain every 4 hours. Not to be taken unless the pain is not relieved from Tylenol, Naproxen, Gabapentin and/or Tramadol.

#### What if you still have pain?

Recent Indiana prescribing laws require medical provi patients after 90 days. If in the rare case, your pain m 90 days, the BOSS team will refer this treatment to a l	iders to initiate and follow pain management contracts with nanagement requires prescriptive narcotic medications beyond local pain management specialist.
Patient Signature	Date
Printed Name of Patient	Patient DOB