INJURY CARE
MEDICAL CENTER

GENERAL OFFICE POLICIES

Thank you for coming to our practice!

Thank you in advance for your willingness to complete these forms. We understand that these forms can seem tedious to complete or feel unnecessary. We use them to look at the "big picture" and learn more about you. This helps us tailor a treatment plan to your specific problems, concerns and diagnosis. We strive to provide you with the finest care possible.

The following are a few key points we'd like you to know about our office.

- We completely understand that at past offices you may have felt poorly treated or lost in the "system." You most likely have had to make repeated calls in order to get information that you need. We try very hard to be different, and to treat all our patients with patience, respect and dignity. That being said please know we have a small office staff, so multiple calls and messages slow down resources and only make it harder for us to respond. If we are unable to answer your call, please be sure to leave a detailed message, and trust that we WILL get back to you as soon as we can to address your concern. We care about you! **One message is all you need to leave.**

- We are all concerned with the rising costs of healthcare. As such, Dr. Radnovich works hard to come up with cost effective treatment. However, his first priority is you getting better. If at any time you have concerns with treatment costs, please discuss this with Dr. Radnovich.

- Insurance co-pays are expected at time of service. If you have temporary financial hardship issues and need to discuss a payment plan for services, please feel free to contact Chris to discuss options at 208-577-5904. Please don't ignore her if she calls you.

- Insurance companies may now require you to have a primary care doctor **BEFORE** being treated by Dr. Radnovich, in order for your visits with Dr. Radnovich to be covered. Please be sure to provide us with their full name, and the name of their clinic on the following forms.

- Urine screenings are generally done every 3 months at minimum while on controlled medications. If you have concerns about this, please discuss with Dr. Radnovich.

- If establishing Disability Benefits – Dr. Radnovich will **NOT** be the treating physician for Disability applications, and will not complete disability related forms. (FMLA forms are allowed).

- We prefer that you only use one pharmacy for all of your prescriptions. However, we recognize that depending on the situation, you may need to switch pharmacies on occasion. Please be clear when calling in for prescription refills which pharmacy we need to contact.

- If you are unable to keep an appointment for any reason, please contact our office at least 24 hours in advance, if possible.

We appreciate the confidence you have shown in scheduling an appointment with us, and we look forward to treating you!

Truly,

Dr. Radnovich &
the Injury Care Staff – Patti, Chris, Amanda & Lindsay

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NEW PATIENT REGISTRATION

Patient Name____
First Middle Last

Email______________________________

Social Security Number_________-____________-_____________ Date of Birth _________________________
(Required to process insurance claims)

Address (street)____

Address (city, state, zip)____

Phone (home)_______________________(cell)____________________(work)______________________

Insurance Information:

Guarantor (person who holds the insurance policy) ☐ Self ☐ Parent ☐ Spouse

Guarantor Name____
First Middle Initial Last

Guarantor's Date of Birth___________________

Guarantor's Address____Phone___________________

Guarantor's Social Security #___________________________

(Required to process insurance claims)

Primary Insurance Company Name____

Insurance Policy ID Number______________________________Group #__________________________

☐ I may have secondary insurance.

PLEASE INITIAL THE FOLLOWING:

______ I understand that I am responsible for all charges for services for ________________________.
(Printed Patient Name)

______ I understand that medical decisions are made between doctor and patient. Some insurance companies might call some treatments "medically unnecessary" without regard to Doctor/Patient determination.

______ I understand that a fee is charged for all services, including but not limited to visits, lab work, blood work, examinations, and/or treatments. Some procedures, although shown to be effective, are considered "experimental" and may not be covered.

______ I understand that I am financially responsible for charges if insurance denies my claim.

______ I authorize the release of any and all information or documents (in compliance with HIPPA regulations) to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or my dependants. My signature below will be the equivalent of me signing each claim submitted.

______ I authorize my insurance company to pay Richard Radnovich D.O., P.C., PLLC, all benefits received for claims submitted. Amounts will be credited to my account.

______ I understand and agree that all copayments are due and to be paid at time of service.

______ I understand and agree that once my insurance has been billed, full payment is due within 90 days from the date of service, (and is not contingent upon receiving a statement.)

______ I understand that it is my responsibility to verify if my insurance will cover certain procedures, services, or medication.

______ If I am a Medicare patient, I will be told in advance if a service or procedure is known not to be covered, and submit payment at time of service.

______ I give my consent to the Clinic and Doctor to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OUTLINED ABOVE:

Patient Signature ____ Date:___________________

Printed Patient Name____

Guarantor Signature ____ Date:___________________
(if different from patient)

Guarantor Printed Name ____

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PAST MEDICAL HISTORY

Note: This is a confidential record of your medical history. It will be entered into your electronic medical record in our office. This information will not be released to anyone without your authorization.

Name of Primary Physician: ___________________________ Name of Clinic: ______________________________

Referring Physician (if different) _________________________Name of Clinic: ______________________________

Present complaint/ problem that you need help with: ____

Date of last physical exam: ____________

What other **medical problems, diagnoses, chronic diseases** do you have?_____________________________

____

____

Surgeries: List any surgeries suggested or planned and give approximate dates: _________________________

____

Have you ever been advised to have a surgical procedure that has not been done? ________________________

____

Infections: Please circle if you've had chicken pox, measles, mumps, whooping cough, rheumatic fever, scarlet fever, tuberculosis exposure, or other infection: ____

Medications: List all you currently take:____

____

____

____

Medications You've Tried and Failed (please be specific)

Medicine (name, dosage)	Start Date (approx.)	End Date (approx.)	Side Effects/Problems

Allergies: Please list all known allergies:____

____

What type of allergic reactions do you have to each of the above mentioned items?____

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Review of Symptoms

Please Circle any of the following problems or symptoms which you may have:

General Health: weakness, fatigue, body aches, headaches, poor appetite, excessive appetite,

Other ____

Skin: hives, eczema, dryness, itching, rash, changes in moles or skin color, changes in nails

Other ____

Head: headaches, migraines, fainting/loss of consciousness, dizziness, passing out

Other ____

Eyes: blurred vision, double vision, change in vision, pain

Other ____

Ears: changes in hearing, pain, ringing, drainage, vertigo

Other ____

Nose: congestion, runny nose, bloody nose, pain, sinus problems, snoring

Other ____

Throat and Mouth: Frequent sore throat or hoarseness, bleeding gums, pain or difficulty swallowing, dry mouth, sores in mouth, jaw pain, difficulty opening mouth

Other ____

Lungs: shortness of breath, wheezing, asthma, cough, coughing blood, painful breathing

Other ____

Heart and blood vessels: palpitations/fluttering, irregular beat, decreased exercise tolerance, high blood pressure, heart attack, chest pain, swelling in legs, cold or discolored hands or feet, spider or varicose veins, anemia

Other ____

Gastro-Intestinal: abdominal pain, constipation, diarrhea, nausea, vomiting, ulcers, heartburn/indigestion, gall bladder disease, changes in bowel habits, excessive gas, colitis, bloating, dark tarry stools, hemorrhoids

Other ____

Genito-Urinary: frequency, urgency, difficulty starting stream, incomplete emptying, painful urination, changes in bladder function

Other ____

Muscles, Bones and Joints: muscle or joint pain, stiffness, muscle cramps, muscle weakness, joint swelling, fracture, redness, restricted joint motion, arthritis, pain or cramps with exercise, bursitis, fracture, thinning bones,

Specific Joint problems: shoulder, elbow, wrist, hand, fingers, hip, knee, ankle, foot, toes

Other ____

Back and Neck: back pain or stiffness, neck pain or stiffness, restricted motion, disc problems, sciatica, fracture

Other ____

Nerves: numbness or tingling, limb weakness, shaking or tremors, neuralgia, memory loss,

Other ____

Endocrine or Glands: swollen glands, heat or cold intolerance, appetite change, excessive thirst, change in skin texture, hair loss or excessive growth, change in menstrual cycle, excessive urination, hot flushes, thyroid problems, immune problems

Other ____

Psychiatric and Mood: depression, anxiousness, poor energy or motivation, short temper, compulsive behavior, change in mood, problems sleeping, poor concentration,

Other ____

Other condition or problem not listed?

____

____

____

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Social History

Marital Status: □ Single □ Married □ Divorced □ Separated □ Domestic Partnership

Have you ever been treated for, or feel you have a problems with, alcoholism or any substance abuse?

□ No □Yes: If Yes, please give details:____

Do you smoke? □ No □ Yes ________ packs per day □ less than a pack a day □ about a pack a week

Do you drink? □ No □ Yes ________ drink(s) per day □ social occasions □ rarely □ moderately

What kind of work do you do? ____

What types of recreational/relaxation activities do you participate in? ______________________

____

How often? ____

Family Health History

	If Living		If Deceased			*Please check yes or no*		
Family History	**Age**	**Health**	**Age at death**	**Cause**	**Has any blood relative had:**	**Yes**	**No**	**Relation**
Father					**Cancer**			
Mother					**Tuberculosis**			
Brother					**Diabetes**			
Sister					**Heart Trouble**			
Sibling					**High Blood Pressure**			
Sibling					**Stroke**			
Son or daughter					**Arthritis**			
Son or daughter					**Allergic diseases**			
					Nervous or mental diseases			
					Headaches			
					Other			

Women Only

Menstruation History:

Age at onset _______ Regular? □ Yes □ No Pain or cramps? □ Yes □ No

Date of last period: ________ Change in cycle? □ Yes □ No Painful intercourse? □ Yes □ No

Do you take birth control? □ Yes □ No How many children do you have? _____

Do you have any other concerns you would like to have addressed?

____

____

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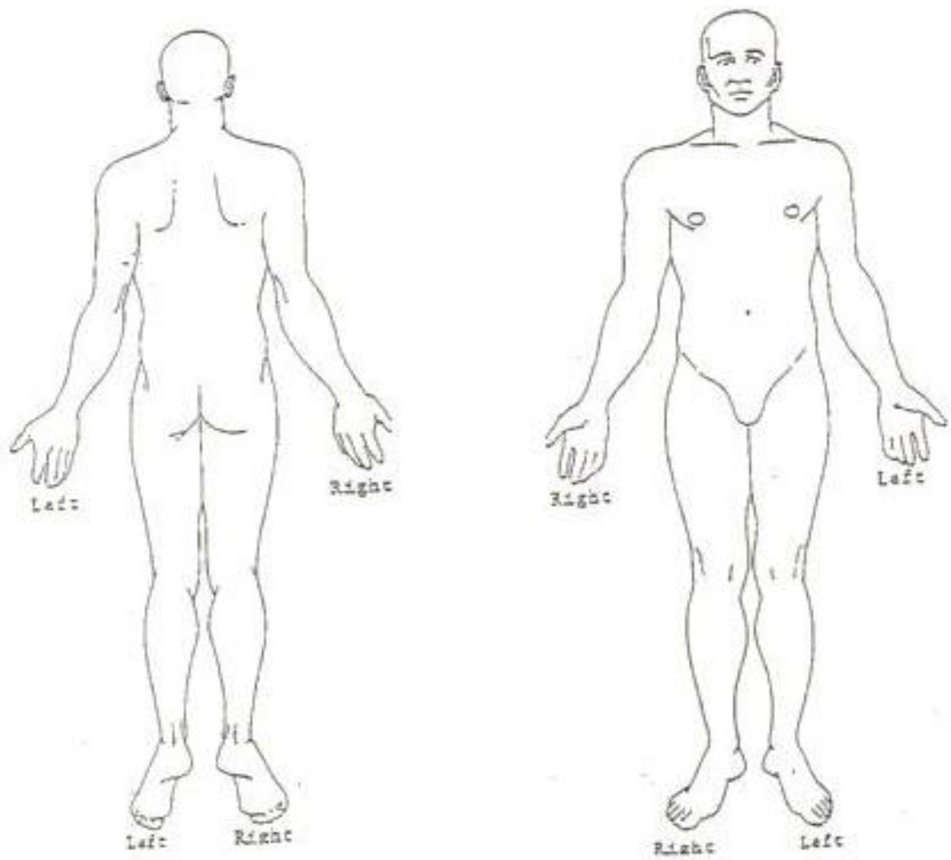
Pain Diagram and Pain Scale

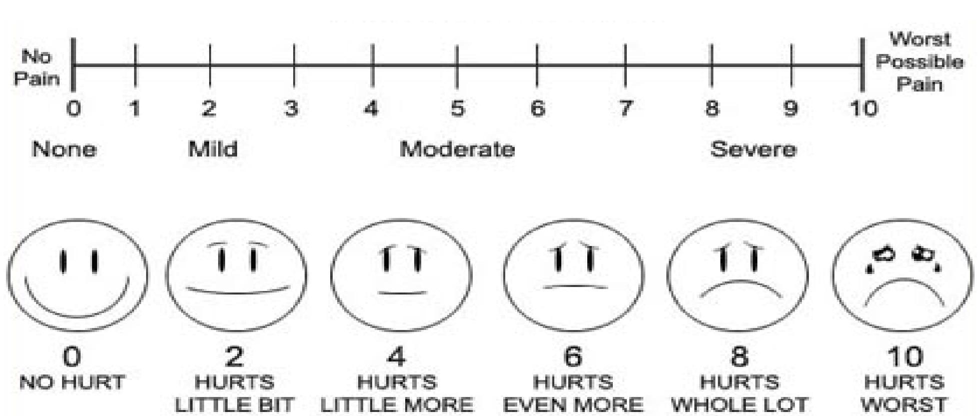
Please mark on this diagram all the areas that you are having pain.

If you have more than 1 type of pain that you would like us to know about, please use the following key:

Aching: - - - -   Tingling, pins or needles: 0000   Burning: XXXX   Sharp or stabbing: ////



Please put an ‘A’ on the scale below to indicate your average pain on a typical day, and put a ‘W’ to indicate the level of your worst pain.



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Patient Name:__________________________

AGREEMENT FOR CONTROLLED SUBSTANCES

We want to help you restore function and help control your pain. To achieve those goals this office is willing to prescribe controlled substances. Controlled substance medications (i.e., narcotics, opiates, sedatives, and barbiturates) can be very useful, but have a significant potential for misuse and are, therefore, closely regulated. They are intended to relieve pain and to improve both function and ability to work. Because this office assumes additional risk by our willingness to prescribe these medications, we ask that you read and agree to the following conditions. Signing this agreement does ***NOT*** indicate that you want these medications nor that we will necessarily prescribe them for you.

☐ ***If I check this box, I do not want controlled prescriptions. However, if I ever get controlled medications l agree to these provisions.***

______1. I am responsible for my controlled medications. If the medications are lost, misplaced, or stolen, ***REGARDLESS OF THE REASON,*** I understand they ***MAY NOT*** be replaced.

______2. I **WILL NOT** request nor accept controlled medications from any other physician or individual while I'm receiving medications from Dr. Radnovich without his prior knowledge. Exceptions include medications I am already taking THAT I HAVE TOLD DR. RADNOVICH ABOUT; or medications prescribed while I am admitted to a hospital.

______3. Refills of controlled medications:

a. Should be made only during **regularly scheduled office visits.**
b. **May not** be made if I "run out early."
c. I am responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining.
d. I will call at least 24 hours but no more than 48 hours before my medications will run out, to arrange for refills. SAME DAY OR WALK IN REQUESTS MAY NOT BE FILLED.
e. I **WILL NOT** call after regular office hours, holidays, Fridays, or weekends for prescription refills.

______4. I **WILL NOT** discard, flush down the toilet, give away or in any way lose control of medications, ***INCLUDING MEDICATIONS THAT I NO LONGER USE***. I will bring in all the medications in their original containers (including the unused portions) each office visit, even if there is no medication remaining.

______5. I **WILL NOT** give, sell or in any manner allow anyone to use medications prescribed for me. Besides being illegal to do so, it may endanger health of those taking my medications.

______6. I **WILL TAKE** the medications as prescribed. Improper use can cause death. It is my responsibility to inform Dr. Radnovich about the success or failure of treatment so he can make appropriate adjustments in my medications.

______7. I understand that the main treatment goal is to improve my ability to function and/or work, not simply to reduce pain. I agree to help myself by following better health habits like regular exercise, weight loss as recommended, and not using tobacco or alcohol. I understand that following a healthier lifestyle will help me reduce my pain and improve function.

______8. I **WILL NOT** use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens.

______9. I **WILL NOT** drive or use machinery or dangerous equipment if I am feeling tired or impaired, or if I have been told that I am impaired. I will notify Dr. Radnovich if this happens.

_____10. In order for Dr. Radnovich to monitor my compliance with proper medication use, I agree to drug testing. I also waive certain privacy rights, including talking with other health care providers, family members and, if necessary, law enforcement officials. In addition, I will come into the office when asked for testing and to produce unused portions of medications to verify they are being taken as directed.

_____11. I have been fully informed by Dr. Radnovich and/or his staff regarding psychological and physical dependence to controlled substances. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same level of pain control. I also know that I may become physically dependent of the medications, and stopping the medications suddenly may cause serious withdrawal symptoms.

_____12. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Dr. Radnovich may be immediately terminated and I risk experiencing withdrawal symptoms. This information may also be reported to my other healthcare providers, medical facilities, and law enforcement officials.

_____13. I have read this agreement. It has been explained to me by Dr. Radnovich and/or his staff. I fully understand the consequences of violating this agreement.

_____ 14. I am taking these medications to control my severe pain, which has not responded to lesser medications.

Signature ____ Date ___________ Witness initial _________________

Patient Name:_________________________

NOTICE OF PRIVACY PRACTICES

☐ ***Please check this box if you authorize your emergency contact to speak with our staff (Dr., NP, MA, or other Staff) regarding your appointments/healthcare, medications, and/or treatment. Please list their information below:***

Emergency Contact______________________Relationship________________Phone_________________

Typical Uses and Disclosures of Health Information
We will keep your health information confidential, using it only for the following purposes:

- **Treatment:** We may use your health information to provide you with our professional services. We have established privacy practices to assure non-essential persons do not view your information. By signing below, you acknowledge that our clinic also contains a medical research facility, and my contact & medical information may be released in order to provide me with new treatment options.
- **Disclosure:** We may disclose your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy also. Information may also be shared with your family, friends and/or other persons you choose to have involved in your care, only if you agree that we may do so. If you wish to restrict information, please let us know in writing: 1) the information you wish to have restricted 2) whom you want the limits applied to.
- **Payment:** We may use and disclose your health information to seek payment for services we provide you. This may include our business office staff and insurance companies, or other businesses involved in the process of mailing statements and/or collecting unpaid balances.
- **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. You may designate an emergency contact and we will use our professional judgment to determine which information will be disclosed. We will also use or professional judgment to make reasonable inference of your best interest by allowing your designee to pick up prescriptions, x-rays or other similar forms of health information or supplies unless you have advised us otherwise.
- **Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, database managers, outside health or management reviewers and individuals performing similar activities.
- **Required by Law:** We will disclose your healthcare information where required by law, court or administrative orders, subpoena, discovery request, or other lawful process. Also, for the use as requested lawfully by national security, intelligence and other State and Federal officials, and/or if you are an inmate.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes, or if you are homicidal or suicidal. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
- **Public Health Responsibilities:** We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, disease or infection exposure and to prevent and control disease, injury or disability.
- **Marketing/Research:** We will not use your health information for marketing or research purposes without your written authorization to do so.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters.
- **Access:** You may inspect and receive copies of your health information, or that of an individual for whom you are a legal guardian. There may be a small fee for copies and postage and we may request you make an appointment to review your chart. If you wish any of your health information to be amended, you must submit your request in writing with an explanation of why you feel it should be changed. Under certain circumstances, your request may be denied.
- **Complaints:** You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.

Signature:____ Date:____________

This document describes how your health information may be used or given to others. It also explains how to access this information. Please review it carefully – you may request a copy of this document at any time.