Washington
Nerve Institute

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www.DucicMD.com

REGISTRATION FORM

_____
Today's Date

Name (Last, First): _____ Date of Birth: _____ Age: _____

In preparation for your office visit with Dr. Ducic, **please read this document** carefully as it contains important information and instructions related to your care. You should read every offered choice and make sure you select ALL pertinent answers. **Upon completion**, you are required to sign it, than save it to your desktop and email it to our office at info@DucicMD.com. Alternatively, if you do not have an electronic signature option, you can enter your initials and the date of birth, being accepted as your signature, or you can print out the entire form, sign and fax it to us. Lastly you can bring completed and signed forms on the day of your office visit, but that will add additional time to your office visit due to required scanning process. This registration form relates to the information about:

- Your Demographics
- Pertinent Medical Concerns
- Insurance
- Registration Terms and Conditions

For your first office appointment, following documents should also be submitted (our preference is that you scan each of these documents and email it to us as a PDF file or fax it prior to your office visit, what can significantly reduce your wait time):

- Completed and signed Registration Package, including terms and conditions
- Valid insurance card and your driver's license
- Referral from your doctor (unless self pay patient or unless not required per your plan)
- Workers comp patients must have written approval by their adjustor for office evaluation
- Written report of relevant CT, MRI, US or nerve studies (NCS/EMG), when done
- Written report of relevant previous surgeries (pertinent operative reports only)

We want to thank you for following the above instructions, thereby allowing us to provide you with a better care.

Sincerely,

Ivica Ducic, MD, PhD

PERSONAL INFORMATION:

Name (Last, First): _____ Date of Birth: _____ Age: _____

Gender: Male ___ Female ___ Marital Status: _____ Race:_____

Address: _____

Home Phone: _____ Cell Phone: _____ email: _____

Emergency contact: _____ Phone: _____ Relationship: _____

PCP & REFERRING MD:

Primary Care Physician (Last, First): _____ Phone: _____

Address: _____ Fax: _____

Referring Physician (Last, First): _____ Phone: _____

Address: _____ Fax: _____

EMPLOYMENT:

Your Occupation: _____ ___ Student ___ Retired ___ Unemployed

Employer Name: _____ Phone: _____ Years Employed:____

Employer Address: _____

INSURANCE GUARANTOR:

Name (Last, First): _____ Relationship to Patient: _____

Guarantor Address: _____ Phone: _____

Guarantor Employer: _____ Phone: _____

INSURANCE:

Primary Insurance: _____ Address:_____ Phone: _____

Subscriber's Name: _____ DOB: _____ Effective Date: _____

ID / Policy Number: _____ Group number: _____

Secondary Insurance: _____ Address:_____ Phone: _____

Subscriber's Name: _____ DOB: _____ Effective Date: _____

ID / Policy Number: _____ Group number: _____

* Do not forget to provide a copy of your valid insurance card and your driver's license *

WORMKEN'S COMP (for those with work-related injuries):

Case Number: _____ Injury Date: _____

Case Worker Name: _____ Phone: _____ Fax: _____

Insurance Carrier Name : _____ Phone: _____

Claims Address: _____

PAST MEDICAL HISTORY:

Please read every choice and complete all pertinent fields. If none check here: ____

Blood Clots ____ (Where: Legs ____ Arms ____ Pulmonary Embolism ____ Other _____)

Coagulation Deficiency ____ (Which one: _____), HIV ____, Hepatitis B/C ____

Anaphylaxis ____ (reaction to what: _____), Malignant Hypertension ____

Heart Attack ____, Hypertension ____, Stroke ____, Seizures ____, Asthma ____, Sleep Apnea ____

Diabetes ____ (IDDM ____ or NIDDM ____), Cancer ____ (Which one/Where: _____)

Smoking ____ (Actively ____, Former ____), Infection by MRSA/VRE ____, Anxiety ____, Depression ____

Concussion ____, Thyroid Disease ____ (Which one: _____)

Liver Disease ____ (Type: _____), Kidney Disease ____ (Type: _____)

Autoimmune Condition: ____ (Lupus ____, Chrohn's ____, RA ____, Other: _____)

Any other medical problems you had in the past: _____

_____

PAST SURGICAL HISTORY:

Type and date of your most recent surgeries. If none check here: ____

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Other: _____

Did you experience any surgical complications or anesthesia problems related to these surgeries: No ____

If yes, please briefly state what: _____

_____

PHARMACY INFORMATION:

Name: _____ Phone: _____ Fax: _____

Pharmacy Address: _____

ALLERGIES:

List any and all allergies you have. If no known drug allergies, check here: ☐

1) Allergic to: _____ Reaction _____

2) Allergic to: _____ Reaction _____

3) Allergic to: _____ Reaction _____

4) Allergic to: _____ Reaction _____

Other allergies: _____

(If you have additional allergies, please provide detailed list)

MEDICATIONS:

List all medications you currently take. If none check here: ☐

1) Name: _____ Dosage: _____ Frequency: _____

2) Name: _____ Dosage: _____ Frequency: _____

3) Name: _____ Dosage: _____ Frequency: _____

4) Name: _____ Dosage: _____ Frequency: _____

5) Name: _____ Dosage: _____ Frequency: _____

6) Name: _____ Dosage: _____ Frequency: _____

7) Name: _____ Dosage: _____ Frequency: _____

8) Name: _____ Dosage: _____ Frequency: _____

9) Name: _____ Dosage: _____ Frequency: _____

10) Name: _____ Dosage: _____ Frequency: _____

11) Name: _____ Dosage: _____ Frequency: _____

12) Name: _____ Dosage: _____ Frequency: _____

13) Name: _____ Dosage: _____ Frequency: _____

14) Name: _____ Dosage: _____ Frequency: _____

Other: _____

FAMILY HISTORY:

Please read every choice and complete all pertinent fields. If none check here: ____

Diabetes ____, Stroke ____, Heart Disease ____ Bleeding tendency ____, Peripheral Neuropathy ____

Skin cancer ____, Other Cancer ____, Depression ____, Other _____

SOCIAL HISTORY:

Please read every choice and complete all pertinent fields.

Smoking Status: No ____, Yes ____ (Packs / day: _____), Former ____ (Quit date or year _____)

Alcohol: None ____, Rare ____, Occasionally ____, Frequently (Glasses per day: _____)

Exercise Activities: Every day ____, Few times per week ____, Not enough ____ None____

Enter Your: Height: _____, Weight: _____ (LBS), Age _____, BMI _____ (office)

THE BRIEF SUMMARY OF MY CURRENT MEDICAL PROBLEMS

Please use next page (#6), to describe in your own words your current health concern. Make sure you include comments to the questions in following paragraphs:

- 1st paragraph: State what is your current problem
  - Comment if includes pain, numbness, burning, muscle function loss, headache, other)
  - How it negatively affects you to function as a person (significantly or moderately, constantly or intermittently, pain level 0-10)
  - How it affects your daily activities, sleep, ambulation, concentration
  - How it affects you professionally (at work/school)
- 2nd paragraph: State when it started (for how long you have it)
  - If known, what might have triggered it (following trauma, surgery, or else, if anything)
- 3rd paragraph: Describe what diagnostic tests you had relevant to your current condition
  - These might include LAB work, X-Ray of…, Ultrasound of…, CT of…, MRI of…, Nerve Block of what nerves…, Botox to…)
- 4th paragraph: Describe what specialists you saw and what treatments you had for your current condition
  - To simplify, you can list the type of specialists you saw
    - Please comment if any of them managed to resolve you current problem
  - List the type of intervention or surgery you had (if any) to address current problem
    - Comment if medical treatment you had alone helped reverse the problem
    - Comment if any of the interventions/surgeries managed to help
- 5th paragraph: Conclude by stating, despite all tests, evaluations and treatments if your condition is continuing to negatively affect you at the present time, being the reason for requesting surgical care.

BEFORE YOU MOVE ONTO THE NEXT PAGE AND PROVIDE THESE ANSWERS, NOTE THAT WHAT YOU ENTER MIGHT HELP INSURANCE CARRIER TO EASIER APPROVE YOUR SURGERY, SO PLEASE TAKE YOUR TIME AND PROVIDE THE BEST AND THE MOST OBJECTIVE ANSWERS TO SUGGESTED QUESTIONS IN THESE FIVE PARAGRAPHS. The entire page (next page, #6) is allocated for this purpose at your convenience. THANK YOU.

Name (Last, First): _____ Date of Birth: _____ Age: _____

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Electronically submitted by _____ on _____.

REGISTRATION TERMS & CONDITIONS

Registration Terms and Conditions are the same and are applied to all patients, regardless of their presenting problem. You are instructed to **read, sign/initial and date** this **important document** since it is offered to you only at the time of initial office visit, but applies to all of your present and future office visits, procedures, surgeries or hospitalizations involving Dr. Ducic's services. Although this form contains number of rules and regulations, it is actually designed to allow us to properly process your claims and provide appropriate and fair care to all our patients. Your appointment letter summarizes necessary documentation needed to register you in our office.

Appointments: All appointments with Dr. Ducic and Washington Nerve Institute staff are made by calling our main line (703 992-9233). If we are on the other line assisting other patients or are away from the desk, please leave the message on this number and your call will be returned the same day or within 24 hours. All communications with our office should be done via phone, as much as is possible.

If you have to change the date or time of your office visit, you need to let our office know of your schedule change *at least 48 hours prior to your scheduled appointment time*. If you cancel or reschedule office appointment within 48 hours of your scheduled date/time, or if you do not show up for your office appointment, you will be charged $250 if you are a new patient (any new patient or consultation); $125 if returning patient (any returning patient) or $75 if post-op patient (< 30 days of surgery or procedure). Since many patients are traveling from out of town or come from distant places, and are waiting sometimes for several weeks for the next available appointment, then your understanding (agreement) regarding this no-exception appointment policy is appreciated (required). Please note that these are self-pay, non-refundable fees and not applicable to your insurance.

Professional Photographs. Some patients requiring *reconstructive plastic surgery*, in order to be pre-certified by their insurance companies for surgery, or for a comparison of their pre- and post-operative results will need to have photographs taken in our office or in the OR. If reprint or electronic copy is requested, separate fee per slide is applied according to the Administrative and Consulting form.

Office Procedures. If the office procedure is scheduled for removal of a skin mole or minor soft tissue procedure, your cancellation or rescheduling within 48 hours from scheduled procedure or a no show on the day of procedure will result in $250 self pay charge to you. Please note that this is a self-pay, non-refundable fee and not applicable to your insurance. Your notice of minimum of 48 hours to us prior to your scheduled office procedure will eliminate the need for this fee.

Surgeries: Following the initial office consultation, unless already done, all patients should call our office (703 992-9233) to select the available date and time for surgery. Our office will, for all insurance cases, contact your insurance company on behalf of you and will provide them with proper documentation in order to have your surgery covered by your insurance plan. Considering out-of network status for certain carriers, we might need to spend significant amount of time and efforts working on approval by your insurance carrier. In the case they would refuse to cover your surgery, we will instruct how to proceed from there. Once we receive confirmation from your insurance, our office will contact you. You will have further communication with our nursing staff, assistants and the surgery center/hospital pre-op personnel in preparation for your surgery. If you do not hear from us, latest a week prior to your surgery, or if you have more questions, you should call us.

All self-pay patients are expected to pre-pay all charged fees prior to the surgery date. Self pay diagnosis code will be used for all self-pay cases (regardless if they are cosmetic, reconstructive or peripheral nerve surgeries), indicating to our billing staff a self pay procedure. All self-pay patients do hereby agree that they will not submit charges for their self-pay surgeries to any insurance carrier. All patients cancelling or rescheduling surgery within 48 hours of already scheduled date/time will be charged $2500. Those not showing up for scheduled surgery will be charged full amount they paid. Please note that these are self-pay, non-refundable fees and not applicable to your insurance. We kindly ask you to follow given instructions so none of these cancelation policies would ever need to be applied.

Payments: With your signature on this form, you confirm you understand and agree that you are ultimately responsible for the services ever related to Dr. Ducic. This includes all fees, co-payments and deductibles due at the time of the services, all fees associated with surgeries, hospitalizations, office visits, procedures, as well as fees for any aforementioned cancellations, short notice rescheduling's, no shows or any administrative services. If you are a self pay, if your insurance coverage expired or was denied for the services we provided to you, or if you have an outstanding copayment/deductible balance, failure to fully clear your balance within 120 days from the service date will mandate involvement of a collection agency or a legal representative. In addition to the total principal balance, you will then be also responsible for 10% daily interest rate for your principle balance remaining after 120 days, all expenses related to collection agency, legal representative and/or court fees. This applies to all patients, regardless if the services were rendered for cosmetic, nerve or reconstructive reasons. Please note that the payment for your deductibles and/or co-payments is your mandatory obligation as per our and your contractual agreement with your insurance company, thus we cannot write it off. This is the most common reason for patients to end up with collection agency, in what case not-paid balance as low as $20 can ruin your credit scores. In addition, until the balance is cleared, you will be waived subsequent office visits. To prevent this from occurring, we ask you to take care of your financial responsibility. If insurance sent you the payment for Dr. Ducic services, you are obligated to forward the check to Dr. Ducic upon receipt.

Completion of forms related to your treatment: For completion and processing of forms you would subsequently submit to us for your business or personal use (like disability, parking, school, work, etc), you need to provide the payment due at the time of the service ($30 for one page form, $40 for two, $45 for three and $50 for four page form). Standard time for processing is approximately 3-5 business days.

Copy of records: With your proper written authorization, we will release your records to you or an addressee you indicated. Based on the number of pages, you will be notified about the processing fee ($20 for up to ten pages, then $1.50/page, plus postage). If peri-operative photos are taken, and a copy is requested, those prints are separately charged in addition to the above fees. By ordering the copy of the records you agree to provide the payment within two weeks from the receipt of the records.

Legal representation: If you are involved in a legal dispute with a third party, and will require Dr. Ducic's report or any testimony, as your treating provider or an expert witness, you agree to pay for any provided administrative and consulting services, as stated in the Consulting and Administrative fee schedule. You, the undersigned patient hereby acknowledge your personal financial responsibility and agree that these fees apply regardless if you, your legal representative, court and/or any other party or jurisdiction had requested or subpoenaed these services, as long as they relate to your name.

Your data future changes: If your insurance company, your address, or phone contact numbers change in the future, we request you inform us about it and submit it on a separate page at the time of your office visit.

Other future changes: Sometimes, due to unpredictable situations or factors not directly controlled by our office, we reserve the right to change the date or time of your office visit, office procedure or surgery. We will under such conditions notify you and will do our best to appropriately accommodate your and our schedules.

I, the undersigned patient (guarantor) have read and fully agree with all Registration Terms and Conditions.

_____ _____

Patient Name Date

_____

Patient (Representative) Signature

(If unable to electronically sign, accepted alternative to signature: Your Initials + Date of Birth): _____