

Marc N. Dubick, M.D.

2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, South Carolina 29414
(843)573-3444 fax (843)769-4312

Patient: _____

Appointment Day: _____

Date: _____ Time: _____

Welcome to the office of Dr. Marc Dubick.

Please read each form and fill it out **completely in BLUE OR BLACK ink.**

If you have questions about any of the forms, please call us before your appointment
(843) 573-3444.

On the day of your appointment, please bring the following:

- 1) This COMPLETED Packet
- 2) Insurance Card and Photo ID
- 3) Recent office notes from your referring doctor, and any MRI/X-Ray reports
These reports and office notes may also be faxed to (843) 769-4312 prior to
your appointment.
- 4) Wear comfortable and loose fitting clothing

Due to environmental sensitivities, Dr. Dubick reserves the right to reschedule any patient who presents smelling of cigarettes, perfume or cologne.

Please plan to spend *at least* one hour in our office.

**We require at least 24 hours notice if you are unable to keep your appointment
or if you wish to reschedule.**

Bring these forms with you on the date of your appointment or mail to the above address.

Driving Directions From Interstate 526

Take exit 11B 461/North Glenn McConnell Parkway. Merge left and make a left at the first traffic light onto Magwood Rd. At first stop sign, turn right and then left into parking area for West Medical Offices. Dr. Dubick's office is in the WEST tower of the Main Hospital Building, Suite 203 West, above the Women and Children's Wing.

**For more detailed directions please visit our website
www.prolotherapysc.com**

We look forward to meeting you!

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PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. ____
Address: _____ City: _____ State: ____ ZIP ____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
e-mail: _____
Birthdate: __ / __ / __ Sex: M __ F __ Marital Status: S __ M __ D __ Sep. ____
Social Security # ____ - ____ - ____ Occupation: _____
Employer: _____ Phone: (____) _____ - _____
Emergency contact: _____ Relationship: _____
Phone: (____) _____ - _____

INSURANCE INFORMATION

Insurance Company: _____
ID# _____ **Group #** _____
Insured's Name or Responsible Party: _____ Relationship _____
Insured's Birthdate: ____ / ____ / ____ **S.S. #** ____ - ____ - ____
Address (if different from patient): _____
City: _____ State: ____ Phone: (____) ____ - ____ Occupation _____
Employer: _____ Address: _____ City: _____
State: ____ ZIP: ____ Phone: (____) ____ - ____ FAX: (____) ____ - ____
Secondary Insurance: _____
ID# _____ **Group #** _____ **Name on Card:** _____

Please provide receptionist with all insurance cards

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with _____. I assign directly to Marc N. Dubick, M.D., all insurance benefits otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment for services.

CONSENT TO TREAT

I, the undersigned (or other responsible party) do voluntarily give my consent to Marc Dubick, M.D., and the professional medical staff of Marc N. Dubick, M.D., to provide medical care, including examination, diagnostic testing & procedures and treatment to me, or to my dependent, as judged to be necessary and appropriate. I acknowledge that no guarantees of effectiveness are expressed or implied, that I have the right to decide the extent of my health care, including referrals to other health care facilities or professionals, and that I may refuse treatment.

_____/_____/_____
Patient (Or Responsible Party) Signature Relationship Date

Marc N. Dubick, M.D.
Point of Service Collection Policy

Dr. Dubick wants to assist you in the financial management of our relationship. Please be advised of our billing and collection policy. Be assured that we will be ethical and fair concerning any billing or collection concern you may have. We do NOT offer payment plans in this office.

Participating Provider Plans

- A list of all participating provider plans is posted at the check-in window for your convenience.
- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current available insurance cards at the time of service.
- The patient is responsible for all co-pays, deductible, and co-insurance at the time of service.
- The patient is responsible for knowing their policy coverage, deductible, co-pays, co-insurance, etc.
- The patient is responsible for insurance follow-up with their plans regarding student status forms, annual employer claim forms, accident/injury information, terminated insurance plans, and any address changes.

Non-Participating Provider Plans

- Patients with out of network insurance coverage will be considered self-pay and responsible for the full balance at time of service.
- Our billing department is happy to provide an itemized receipt if you choose to file your own claims. In the rare case your insurance company sends payments to the practice a refund will be issued within 14 business days.

Medicaid

- Patients with Medicaid coverage will be considered self-pay and responsible for full balance at the time of service.
- Patient understands visits with Dr. Dubick cannot be filed to Medicaid _____
Signature

Self-Pay Patients

- Patients with no insurance coverage will be considered self-pay and responsible for full balance at the time of service.
- Self-pay patients will sign this form indicating that they have NO health insurance coverage.

Collections

- Collection notices begin if the balance has not been paid within 90 days.
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted. Patient is Responsible for all Collection Agency Fees. This will result in negative credit rating.

Termination

- Dr. Marc Dubick expects payment when services are rendered. Failure to make payment could jeopardize your patient/physician relationship. You may receive a letter at any time proving proper notification of the physician's intent to terminate the relationship as a result of non-payment for services rendered.

_____ I do NOT have health insurance.

_____ I have health insurance coverage with _____ (company name).

Patient Signature

Date

Office Staff Signature

Date

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PATIENT ASSESSMENT FORM

Name _____ Date of Birth ____ / ____ / ____ Age _____

Date _____ Social Security # _____ - _____ - _____

Referring Health Care Professional/Specialty _____

Address _____

Primary Care Physician _____

Address _____

Social History

Occupation: Present 1. _____
Past 2. _____ 3. _____

Smoking History (how long and how much): _____

Alcohol Usage (how much per week): _____

HISTORY OF PRESENT ILLNESS

Chief Complaint (Subjective):

General (Include onset/event, date of injury, secondary pain complaints):

Previous Diagnosis and Treatment: _____

Primary Location of Pain: _____

Location of Radiation: _____

Duration of Pain (how long has it been present?): _____

When during the day is the pain the worst? _____

Pain Severity (0-10): At Rest: _____ With Activity: _____ With Medication: _____

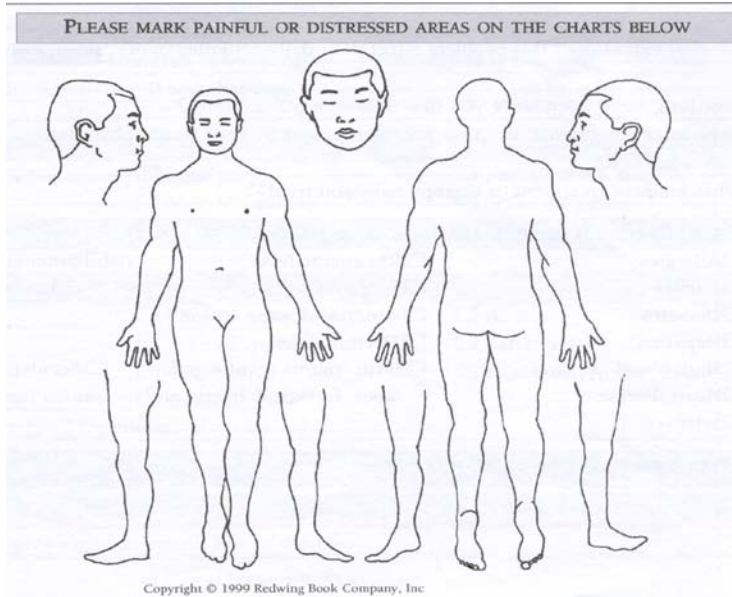
Name and Effect of Medication used: _____

Pain Quality: (Check all applicable) _____ Burning _____ Stabbing
_____ Spasm _____ Stinging _____ Tingling _____ Numbness
_____ Aching _____ Tender _____ Throbbing

Label the Factors That Increase (I), Decrease (D), or do not affect (N/A) Pain:

- | | | |
|---------------------------------|------------------------|-------------------------------|
| _____ Lying Down | _____ Sitting | _____ Standing |
| _____ Driving | _____ Walking | _____ Lifting |
| _____ Limb Position | _____ Heat Packs | _____ Cold Packs |
| _____ Rest | _____ Massage | _____ Position Change |
| _____ TENS | _____ Physical Therapy | _____ E-Stim |
| _____ Warm Weather | _____ Cold Weather | _____ Weather Changes |
| _____ Extension of back or neck | | _____ Flexion of back or neck |

PAIN DIAGRAM



Diagnostic Tests: (MRI, CT scan, EMG, NCS, X ray, Myelogram, Bone Scan)

Date: _____ Test: _____ Facility: _____

Result: (do we have a report?) _____

Laboratory Tests: (within the past 3 months)

Date: _____ Test: _____ Facility: _____

Result: (do we have a report?) _____

What have you tried for your pain?

Physical Therapy/Occupational Therapy:

Dates: _____ Facility: _____

Therapies/Modalities (do they help?) _____

Tens: _____ Home Exercise: _____

Are you doing them consistently? _____

Chiropractor: _____

Massage Therapy: Benefits: _____

Past History Medical

Review of Systems

Past and Present Illnesses (check all that apply)

Constitutional System:

_____ Fever _____ Weight Loss _____ Chronic Fatigue

Eyes: _____ Glaucoma _____ Other: _____

Ear, Nose, Throat: _____

Cardiovascular: _____ Heart Murmur _____ High Blood Pressure
_____ Heart Attack _____ CABG _____ Rheumatic Fever
_____ Angina _____ Thrombophlebitis
Other: _____

Respiratory: _____ Asthma _____ Emphysema _____ Chronic Bronchitis
_____ Positive TB Skin Test _____ Tuberculosis

Gastrointestinal: _____ Cirrhosis _____ Hepatitis _____ Diverticulosis _____ Ulcers
_____ Gall Stones _____ Pancreatitis _____ Liver Disease
Other: _____

Genitourinary: _____ Kidney Infection _____ Kidney Stones
Other: _____

Musculoskeletal: _____ Arthritis _____ Fractures _____ Fibromyalgia
Other: _____

Integumentary (Skin and/or Breast): _____

Neurological: _____ Seizure Disorder _____ Stroke Other: _____

Psychiatric: _____

Endocrine: _____ Diabetes _____ Thyroid Other: _____

Hematologic/Lymphatic: _____ Poor Blood Clotting _____ Anemia _____ Blood Transfusions
Other: _____

Allergic/Immunologic: _____

Cancer: _____

Other: _____

Hospitalizations and Surgeries (what, when):

_____	_____
_____	_____
_____	_____
_____	_____

Allergies (medications, environmental and foods):

_____	_____
_____	_____
_____	_____

Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Have any blood relatives had any of the following? (check all that apply)

	<u>Relationship</u>		<u>Relationship</u>
___ Asthma	_____	___ Alcoholism	_____
___ Bleeding Disorder	_____	___ Migraine Headaches	_____
___ Cancer	_____	___ Obesity	_____
___ Diabetes	_____	___ Stroke/Heart Disease	_____
___ Allergies	_____	___ Thyroid Disease	_____
___ High Blood Pressure	_____	___ Tuberculosis	_____
___ Kidney Disease	_____	___ Osteoporosis	_____

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**CONTRACT FOR OPIOID (NARCOTIC) PRESCRIPTION & MANAGEMENT
Patient Consent & Use**

This contract is made by and between Marc N. Dubick, M.D. and the patient whose signature appears below, and is for the purpose of clarifying conditions for the prescription / use of pain-controlling medications. Because opioid (narcotic) drugs are controlled substances, the patient herein acknowledges the necessity for maintaining trust and confidentiality in the doctor / patient relationship, of which this contract is a part.

I, (Patient) _____, agree to and accept the following conditions for the management of pain through the use of prescribed opioids:

Opioid medications may be prescribed by: Dr. Marc Dubick. Examples of opioid medications are, but are not limited to: morphine (MS Contin, Roxanol & others); codeine (Tylenol#3 & others); hydrocodone (Lortab, Vicodin & others); Oxycodone (Oxycontin, OxyIR & others); Roxicodone (Percocet, Percodan, Tylox & others); Methadone (Dolophine); meperidine (Demerol); hydromorphone (Dilaudid); hydromorphone (Numorphan); propoxyphene (Darvon, Darvocet & others), and medications that may, from time-to-time, be approved for use. This information is given to me so that I know, and therefore have the responsibility for knowing, if there are opioids in any medication prescribed for me.

I understand that a reduction in the intensity of my pain and the improvement in my quality of life are goals within this pain management program.

I understand that all medications have side effects and that I have been informed by my doctor of this potential including, but not limited to: physical dependence, pseudo-addiction, chemical dependence (addiction), constipation (which could be severe enough to require medical treatment), difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respirations, reduced sexual function, and adverse effects or injury to organs. I acknowledge that, if I take more medication than what is prescribed, I risk potentially dangerous consequences such as: coma, organ damage, or even death. I, therefore, consent to the recommended laboratory studies required to keep the medication regimen as safe as possible.

I agree that I will exercise caution and good judgment when performing activities such as driving, operating machinery, using appliances, etc.

I agree not to use any illegal substances including: marijuana, cocaine, heroin, etc.

I agree not to use the medication with alcohol or any beverages containing alcohol.

I agree not to share, sell, or trade my medication for money, goods, services, or for any other reason.

I agree that I will not attempt to get pain medication from any other health care provider without informing that provider that I am currently taking medication prescribed by Dr.Dubick, and I understand that to do so is against the law. If another health care provider is willing to prescribe medication, Dr.Dubick will first have to approve the arrangement to assure that there is no duplication. If a change is made,

Marc N. Dubick, M.D. – Opioid Contract – Page 2

I agree to bring any remaining pain medications in their proper containers to Marc N. Dubick, M.D. to be counted and discarded before a new prescription is issued to me by another provider.

I agree that I will safeguard my medication from loss or theft and further agree that failure to do so may result in my being without the medication for a period of time.

I agree that I will use _____ Pharmacy, located at: _____, (Tel. No. ___ - ___ - _____), for filling prescriptions for all of my medications. If for any reason I change pharmacies, I agree that I will notify my doctor at the time I receive a prescription or a renewal of a prescription, and that I will advise my new pharmacy of my prior pharmacy's address and telephone number.

I agree that I will waive any applicable privilege or right of privacy or confidentiality with respect to my receipt of a prescription for opioid medication, and I authorize both my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the South Carolina Board of Pharmacy, in the investigation of any misuse, sale, or other disposition or diversion of my pain medication. I further authorize my doctor to provide a copy of this agreement to my pharmacy.

I agree that I will fully abide by the following additional rules with regard to prescriptions:

1. Prescriptions for my medication will be made in person during a scheduled office visit and only during regular office hours.
2. No prescription will be written or renewed early for any reason, including but not limited to lost, stolen, or destroyed medication.
3. No prescription will be called in over the phone to my pharmacy for any reason.

I agree that I will submit to a blood, saliva or urine test at random if directed by my doctor in order to determine my compliance with this contract and the terms herein regarding my regimen of pain control medication.

I agree to be evaluated by a psychologist or addiction specialist at any time during my treatment if requested by my doctor and if, in the opinion of the psychologist or addiction specialist, I am not a candidate for the continuation of this treatment, then I will be weaned off the medication and an alternative pain management treatment may be sought.

I understand that this medication regimen will be continued for a period of time deemed necessary and appropriate for fair evaluation by my doctor of its effectiveness. I further understand that I will be reviewed at the end of that period and, if there is no evidence that I am improving or that progress is not being made to improve my function or my quality of life, then other specific outlines of pain management may be formulated and recommended.

I agree that this contract is essential to my doctor's ability to treat me effectively, and that my failure to abide by the terms herein, may result in the withdrawal of all prescribed opioid medication by my doctor, and the possible termination of this doctor / patient relationship.

THIS AGREEMENT IS ENTERED INTO ON THIS _____ day of _____, 20_____.

(Patient Signature)

(Office Staff)

Marc N. Dubick, M.D.
NOTICE OF PRIVACY PRACTICES

This notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Contact this office with any questions about this notice

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and correct your PHI, which includes information that may identify you and that relates to your past, present, or future health condition as provided by Marc N. Dubick, M.D.

The posting and distribution to you of this notice is required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective on April 14, 2003. Privacy Standards are enforced by the Office of the Inspector General, Department of Health & Human Services of the United States Government. Marc N. Dubick, MD, PC is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this notice at any time, and any new notice will be effective for all PHI that we maintain at that time, and we will provide you with any revisions upon request.

TYPES OF PERSONAL INFORMATION WE COLLECT

Marc N. Dubick, MD, PC collects and maintains a variety of personal and health information when delivering medical services or providing treatment for you. You provide some of this information when you initially become our patient, such as your address, Social Security Number, employment information, insurance information, and your medical history from other physicians and other health care providers. We limit the collection of PHI to that which is necessary to conduct our business, to provide quality treatment, and to meet regulatory requirements.

HOW PHI IS PROTECTED

Marc N. Dubick, MD, PC treats PHI securely and confidentially. We limit access to that information to only those persons, both inside and outside the practice, who need to know to provide services to you. All individuals are trained on the importance of safeguarding PHI and know that they must comply with practices and procedures and will follow all applicable laws.

Patient Acknowledgment of Receipt

I have been given a copy of this Notice of Privacy Practices for Marc N. Dubick, M.D., and I have been given an opportunity to read it. I understand that if I have any questions or concerns with regard to the Notice, they will be answered and / or explained to me.

SIGNATURE: _____ **NAME:(PRINT)** _____

BIRTHDATE: ____ - ____ - ____ **DATE:** ____ - ____ - ____

(This signed receipt of the Notice of Privacy Practices will be permanently filed with the patient's Medical Record)

Marc N. Dubick, M.D.

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Individual patient (or personal representative) confirming the authorization

I, _____, give my authorization to use or disclose my protected health information as described below.

Please list the family members or other persons, if any, (include name and relationship) whom we may SPEAK with about your medical condition and your diagnosis (including treatment, payment, and health care records):

Can confidential messages (i.e., appointment reminders) be left on your cell, home phone or e-mail? **(I am aware that a cell phone is not a secure and private line)** Please indicate where we may leave messages:

Cell _____ Home _____ Email _____

Release of Records:

Please name the persons (family members, doctors, attorneys, worker's compensation, physical therapists, etc.) whom you are authorizing your protected health information to use and/or disclose and to be released to:

I authorize records to be released to **myself** and the following people:

Please describe the protected health information that you are authorizing to be disclosed: (office notes, MRI, x-rays, billing information, etc.):

Entire Chart **OR** Selected Records Only: as listed below:

This authorization will end on the completion of my treatment unless dated otherwise:

(Only date if **not** ended at completion of treatment) Date: _____

I have read and understand this authorization form and I agree with all statements made in this authorization. I understand, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this form is signed by a personal representative for the individual patient:

Personal Representative Name: _____ Relationship to Patient: _____