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 __ W __

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? __________________________

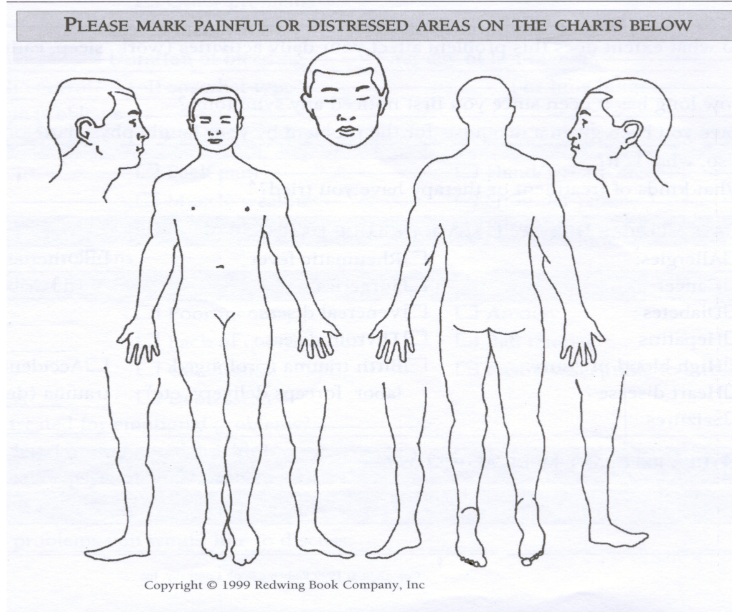
Pain Severity (0-10): At Rest:_____ With Activity: _____ With Medication: ______
Name and Effect of Medication used: ____
____
____

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)

Condition	Relationship	Condition	Relationship
___ 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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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.

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

For the purpose of my medical treatment, I authorize & give permission for Marc N. Dubick and his staff to view/access my pertinent medical records stored electronically at other facilities, including but not limited to hospitals, radiology, physicians' offices, physical therapy and chiropractors. (Please indicate the facilities.)
☐St Francis & Roper ☐ Tricounty Radiology ☐ MUSC ☐ I do NOT give permission to access electronic records
Other:

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: _________________