MARC N. DUBICK M.D.
2097 Henry Tecklenburg Drive, Suite 203 West
Charleston, SC 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**. If you have questions about any of the forms please call our receptionist before your appointment at (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**.**

You may bring these forms with you on the date of your appointment or mail them to the above address.

We look forward to meeting you.

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Directions to our office:

From I-26 East (toward Charleston)
Take I-26 East bound to Charleston. Take I-526 West bound toward Savannah, about five and a half miles. Take Exit 11B 461/North Glenn McConnell Parkway. At first traffic light, turn left into St. Francis-Xavier Hospital. At first stop sign, turn right and then first left into parking area for West Medical Offices. Dr. Dubick's office is Suite 203 West inside the Hospital.

From Downtown Charleston
Take Highway 17 South (toward Savannah) across the Ashley River Bridge. Follow Highway 17 through West Ashley until you reach I-526. Take I-526 East (toward North Charleston/Mt. Pleasant). Take Exit 11B 461/North Glenn McConnell Parkway. At first traffic light, turn left into St. Francis-Xavier Hospital. At first stop sign, turn right and then left into parking area for West Medical Offices. Dr. Dubick's office is Suite 203 West inside the Hospital.

From Beaufort/Savannah
Take Highway 17 North (toward Charleston). Once in West Ashley, take I-526 East (toward North Charleston/Mt. Pleasant). Take Exit 11B 461/North Glenn McConnell Parkway. At first traffic light, turn left into St. Francis-Xavier Hospital. At first stop sign, turn right and then left into parking area for West Medical Offices. Dr. Dubick's office is Suite 203 West inside the Hospital.

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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: ______________________ Address: _________________________________

City: ____________State: ___ ZIP: _____ Phone: (___) ___ - ____ FAX (___) ___- ___

Referred by: ____

In case of Emergency Notify: _________________________ Phone: (___) ____ - _____

INSURANCE INFORMATION

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: (____) ___-_____ ___

Insurance Company:____

ID# ____________________**Group #** ____________ **Name on Card**: ______________

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. Marc Dubick wants to assist you in the financial management of our relationship. Please be advised of our billing and collection policy. If you have any questions, please speak with our billing/collection specialist. Be assured that we will be ethical and fair concerning any billing or collection concern you may have.

Participating Provider Plans

- A list of al 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

- The patient is responsible for the full balance at time of service unless other payment arrangements have been made.
- Our billing department will file the patient insurance as a courtesy. If your insurance company sends payments to the practice rather than to you, a refund will be issued promptly.

Self-Pay Patients

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

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

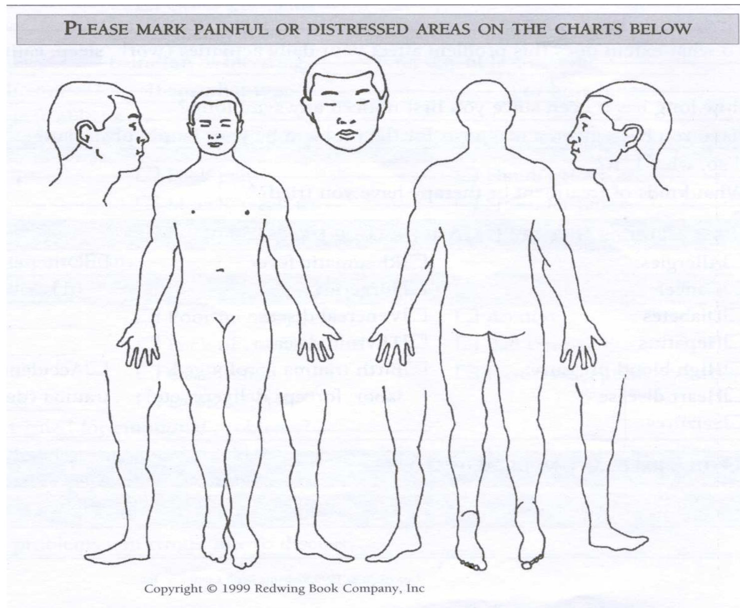
______Spasm ______ Stinging ______Tingling ______Numbness

______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?
<u>Physical Therapy/Occupational Therapy</u>:
Dates:_________________________ Facility: ___________________________________
Therapies/Modalities (do they help?) ____
Tens: ___________________ Home Exercise: ___________________________________
Are you doing them consistently? ____

<u>Chiropractor</u>: ____

<u>Massage Therapy:</u> 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)

	Relationship		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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CONTRACT FOR OPIOID (NARCOTIC) PRESECRIPTION & 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 o 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 that 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 my doctor at Pain Care, and I understand that to do so is against the law. If another health care provider is willing to prescribe medication, my doctor at Pain Care will first have to approve the arrangement to assure that there is no duplication. If a change is made,

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 filing 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 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. Pain Care 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 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)

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INDIVIDUAL PATIENT'S AUTHORIZATION

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

1. Individual patient (or personal representative) confirming the authorization

I give my authorization to use or disclose my protected health information as described below. I give this authorization voluntarily.

Individual Patient's Name: ____

Your Address: ____

Your Telephone Number: ____

2. The use and/or disclosure authorized

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

____

____

____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: ______________________ Phone: ______________________

Name: ______________________ Phone: ______________________

Please print the telephone number or numbers where you want to receive calls about your appointments or other health care information: (_____)____________________________

(_____)____________________________

- **I am fully aware that a cell phone is not a secure and private line**

Can confidential messages (i.e., appointment reminders) be left on your home and/or work answering machine or voicemail?

Home: YES ____________ Work: YES ____________
NO ___________ NO ___________

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

☐ Entire Chart

☐ Selected Records Only:

____

____

Please name the persons (family members, doctors, attorney's, 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:

____

____

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

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

3. **Individual Patient's Signature**

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 Individual Patient: ____

You have a right to a copy of this form after you sign it.