

Marc N. Dubick, M.D.

2097 Henry Tecklenburg Drive

Suite 203 West

Charleston, SC 29414

Phone: 843-573-3444

Fax: 843-769-4312

Patient: _____

Appointment Day: _____ Time: _____

Welcome to The Pain Care and Natural Medicine Center of Charleston. Included in the following packet you will find directions to our office, a patient information sheet, a 4-page patient assessment form, and a point of service collection policy form. Please read each form and fill it out **completely** before your scheduled appointment with Dr. Marc Dubick. If you have questions about any of the forms please call our receptionist before your appointment at (843) 573-3444. You are also responsible for bringing your insurance card and a photo I.D., any recent office notes from your referring doctor, and any MRI/X-Ray reports and/or films. These reports and office notes may also be faxed before your appointment to (843) 769-4312. The following list is a guideline that may assist you in filling out the information needed.

- 1) On the patient information sheet please fill out the top part with all of your correct and most recent information. Under insurance information please list the person's name that the plan is covered by (i.e. spouse, mother, father, self, etc.), also list that person's date of birth, social security #, employer, etc., then sign and date the bottom of the page.
- 2) On the patient assessment form you will need to fill this out to your best knowledge, so Dr. Dubick will know exactly what you are seeing him for, medications you are currently taking, any past problems that relate to your current symptoms, etc. Please read this section carefully and fill out completely.
- 3) On the point of service collection policy form please read carefully, check the appropriate lines, then sign and date the bottom.

We look forward to meeting you. You may bring these forms with you on the date of your appointment or you may mail them to the address at the bottom of the page. We require **at least 24 hours notice** if you are unable to keep your appointment or if you wish to reschedule. Thank-you for your co-operation, we look forward to having you as a new patient.

Marc N. Dubick, M.D.

Marc N. Dubick, M.D.
Anesthesia Pain Management
Prolotherapy

Office 843-573-3444
Fax 843-769-4312

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 Ashley River Road exit North. 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.

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). Exit on Ashley River Road North. 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.

From Beaufort/Savannah

Take Highway 17 North (toward Charleston). Once in West Ashley, take I-526 East (toward North Charleston/Mt. Pleasant). Exit on Ashley River Road North. 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.

2097 Henry Tecklenburg Drive • Suite 203 West • Charleston, SC 29414

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 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

- 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 unless other arrangements have been made prior to visit.

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. 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

MARC N. DUBICK, M.D.
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. _____

Marital Status: ___ S ___ M ___ D _____ Other

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: _____

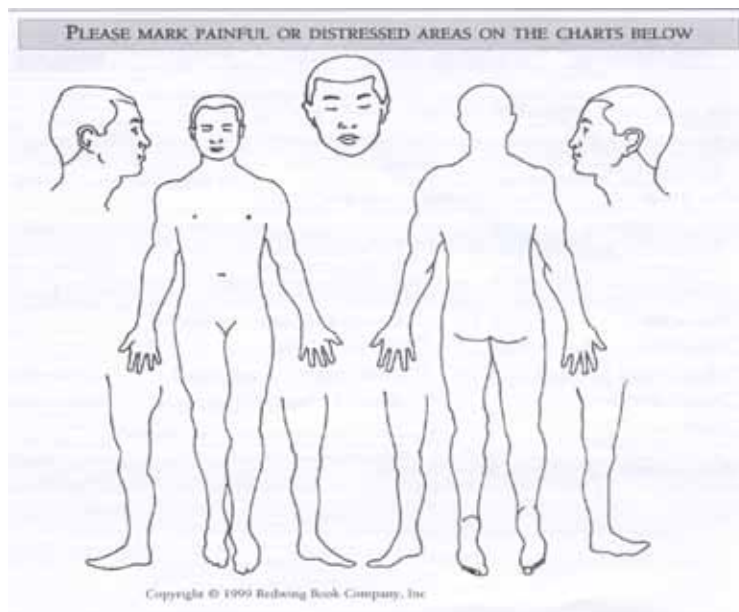
Pain Quality: (Check all applicable)

_____ Spasm _____ Stinging _____ Burning _____ Stabbing
_____ Aching _____ Tender _____ Tingling _____ Numbness
_____ Throbbing

Factors That Increase (I), Decrease (D), or do not effect (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	_____

Pain Care & Natural Medicine Center of Charleston

Marc Dubick, DDS, MD
2097 Henry Tecklenburg Drive, Suite 203 West
Charleston, SC 29414
Tel: 843-573-3444 Fax: 843-769-4312

CONTRACT FOR OPIOID (NARCOTIC) PRESCRIPTION & MANAGEMENT

Patient Consent & Use

This contract is made by and between Pain Care & Natural Medicine Center of Charleston (Pain Care), its physicians and non-physician practitioners, 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: _____, of Pain Care. Examples of opioid medications are, but are not limited to: morphine (MS Contin, Roxanol & others); codeine (Tylenol#3 & others); hydrocodone (Lortabs, 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 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,

Pain Care & Natural Medicine Center of Charleston – Opioid Contract – Page 2

I agree to bring any remaining pain medications in their proper containers to Pain Care 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 and Pain Care 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)

(For Pain Care)

PAIN CARE & NATURAL MEDICINE CENTER OF CHARLESTON

Marc Dubick, DDS, MD

2097 Henry Tecklenburg Drive, Suite 203 West

Charleston, SC 29414

843-573-3444

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 the Pain Care and Natural Medicine of Charleston (Pain Care).

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

Pain Care 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

Pain Care 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.

PAIN CARE & NATURAL MEDICINE CENTER OF CHARLESTON

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NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

I have been given a copy of the Notice of Privacy Practices for Pain Care and Natural Medicine Center of Charleston, 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.

NAME: (PRINT) _____

BIRTHDATE: ____ - ____ - ____

SIGNATURE: _____

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.

2097 Henry Tecklenburg Drive

Suite 203 West

Charleston, SC 29414

Phone: 843-763-2328

Fax: 843-769-4312

Date: _____

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: _____

Your Social Security 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 _____
NO _____

Work: YES _____
NO _____

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

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:

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.