

BROWARD SPINE INSTITUTE, LLC
PAST MEDICAL HISTORY

Are you here through Worker Compensation: **YES** **NO** **Auto Accident:** **YES** **NO**

Date of visit: _____ Name: _____ Date of Birth: _____

S.S.# _____ Phone # _____ Emergency # _____

Who referred you: _____ Primary Doctors Name: _____

What is the main reason or chief complaint for your visit? _____

Occupation: _____ Employer: _____

PAST MEDICAL HISTORY (Place an **"X"** next to any of the conditions below **YOU** have & **CIRCLE** any description)

- | | | |
|--|--|---|
| __ Heart Attack
(Myocardial Infarction) | _____ Stomach Problems, e.g. Gastritis,
Peptic or Duodenal Ulcer Disease | _____ Fractures/Broken
Bones |
| __ Chest Pain (Angina) | _____ Hiatal Hernia , G.E.R.D.
(Gastroesophageal Reflux Disease) | _____ Frequent Falling,
Poor Balance |
| __ Palpitations/Irregular beats,
Rapid heart rate (tachycardia) | _____ Bowel Disturbances, e.g.
Irritable Bowel Syndrome/Colitis Diverticulitis | _____ Nervous System
Disorder |
| __ Heart Valve Disease
(Mitral, Aortic, or Tricuspid) | _____ Prostate Problems (Prostatitis Cancer) | _____ Severe Muscle
Weakness |
| __ Liver Problems/Disease
(Hepatitis B or C, Cirrhosis) | _____ Bleeding Tendency
(Difficulty with clotting, bruise easily) | _____ Epilepsy/Seizures |
| __ Kidney Problems/Disease | _____ Anemia (Iron Deficiency, Pernicious) | _____ Depression |
| __ High Blood Pressure
Attacks | _____ Breathing/Lung Disease (Asthma, COPD,
(Bronchitis, Tuberculosis, Cough up blood) | _____ Panic/Anxiety |
| __ Stroke (CVA or TIA) | _____ Thyroid Disease (Goiter, Tumor,
(Hypothyroidism, Hyperthyroidism) | _____ Migraine Headaches |
| __ Diabetes (Insulin or
Non-insulin dependent) | _____ Glaucoma | _____ Chronic Dizziness,
Vertigo |
| __ Osteo-Arthritis
(Aging Arthritis) | _____ Urinary/Bladder problems (Infections,
incontinence, retention) | _____ Skin Problems,
Cancer
Psoriasis, Eczema |
| __ Gout | _____ History of Cancer (Skin, Breast, Lung, Liver
Stomach, Pancreas, Kidney, Bladder,
Prostate, Uterus, Rectum or Other | _____ Poor Appetite
Weight Loss |
| __ Osteoporosis | | |
| __ Emphysema | _____ Rheumatic Fever | _____ Mental Illness |

Other Conditions: _____

Any Family History of the problems/diseases identified above If YES, Identify who in the family & what problems or diseases.

PATIENT SIGNATURE: _____ DATE: _____

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PAST MEDICAL HISTORY**

Social History: Married Single Divorced Widow Widower Minor

Do you smoke or Chew Tobacco?_____ If Yes, how many years?_____ How many packs per day?_____

Do you Drink Alcohol?_____ If yes, how long and many drinks per day?_____

Is there any substance abuse (Drug abuse) history past or present? {i.e., marijuana, cocaine, heroine, etc.} No Yes

If yes, How long and what substance:_____

Review of Systems: CIRCLE if applicable

EYES: Glasses/Contacts? Blurred vision? Watering eyes? Eye pain?

HENT: Post nasal drip? Hearing problems? Sore throat? Tonsil? Mouth?

CARDIOVASCULAR: High blood pressure? Racing heart? Swelling? SOB? Chest pain?
 MVP? Heart attack? Murmur? Congestive heart failure?
 Pacemaker/Defibrillator? Coronary artery disease? Varicose veins?

RESPIRATORY: Wheezing? Coughing? Chest Colds?

GI: Difficulty swallowing? Gastritis/Ulcers? Reflux? Hiatal Hernia? Heartburn?
 Early satiety? Stomach pain? Diarrhea? Loss of appetite? Blood in stool?

LIVER: Hepatitis A B C? Cirrhosis? If yes Alcoholic/nonalcoholic? Other type of Hepatitis?

GU: Urination problems? Discharges? Post menopausal? Last PAP?

MUSCULOSKELETAL: Aching/swelling of muscles/joint? Muscle cramping? Weakness?

SKIN: Skin problems? Itching? Skin rash? Boils? Persistent Itch?

NEUROLOGIC: Faintness? Numbness? Trembles? Memory? Headache?

PSYCHIATRIC: Nervous with strangers? Depressed? Alcohol/Drug problem?

ENDOCRINE: Thyroid problems? Sweating? Diabetes?

HEMATOLOGIC/LYMPHATIC: AIDS/HIV? Swollen nodes? Excessive bruising/bleeding?

ALLERGIC/IMMUNOLOGIC: Allergic to: reaction:

OTHER: Fever? Chills? Ear infection?
 Are you unhappy with your life? Do you feel severely depressed? Have you considered suicide?

BREAST: _____ Last mammogram?_____

PATIENT SIGNATURE: _____

DATE: _____

**BROWARD SPINE INSTITUTE, LLC
PAST MEDICAL HISTORY**

Prior Surgery/Hospitalizations: NONE

Type of Surgery

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Present Medications: (Include Name, Dose (mg) & how often you take it)

Medication

Dose (mg)

Time per day

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

Allergies to Medication / Food / Environment: NONE

Name of Allergy

Reaction

_____	_____
_____	_____
_____	_____

All **X-RAYS** taken by this office are the property of Broward Spine Institute, LLC. Under no circumstance can originals be taken out of the office. All originals will be maintained by Broward Spine Institute, LLC at all times. If x-rays copies are requested, at least 24 hours notices will be required and there will be a **charge of \$10.00 per film** for labor and film materials. This charge is to be paid in advance. Thank you for your consideration.

PATIENT SIGNATURE: _____

DATE: _____



Marshall E. Stauber M.D., David A. Krant M.D., Roland D. Kaplan D.O. FAAPM&R, Lawrence M. Alexander M.D., Sarah K. Yovino M.D., Daniel A. Wasserman D.O.M, Lillian R Friedman D.C.

NOTICE OF PRIVACY PRACTICES

** ACKNOWLEDGEMENT OF RECEIPT **

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Broward Spine Institute. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any questions about our Notice of Privacy Practices, please contact our Compliance office at:

Medicompliance Solutions, Inc.
350 N.W. 12th Ave, Suite 150
Deerfield Beach, Florida 33442
(866) COMPLY 8 (toll free)

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt of the Notice of Privacy Practices of Broward Spine Institute, LLC.

Signature: _____ Date: _____
(Patient/Parent/Conservator/Guardian)

** INABILITY TO OBTAIN ACKNOWLEDGEMENT **

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment and the reason why the acknowledgment was not obtained:

Signature of provider representative: _____ Date: _____

An acknowledgment was not obtained because:

- [] Patient refused to sign.
[] Patient was unable to sign or initial because: _____
[] There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other Reason: _____



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OFFICE POLICIES

Under Florida Law, Physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR'S MARSHALL E. STAUBER M.D., LAWRENCE M. ALEXANDER M.D., AND SARAH K. YOVINO M.D. HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fall to satisfy adverse judgments arising from claims of medical malpractice. This notice is to provide pursuant to Florida Law.

By law we must inform you that your physician may or may not have a financial interest in a diagnostic center or treatment facility you may be attending.

All patients please call 1/2 hour before scheduled appointment time to find out if the doctor is running on schedule. If he is running behind, we will ask you to call back at an appropriate time to find out when you should come in.

I, the undersigned, do hereby personally guarantee payment for medical care and services rendered. If this account is not paid in full at the time of service, I further authorize the insurance company to pay benefits directly to Broward Spine Institute, LLC. I shall also be responsible for all costs of collections, including reasonable attorney fees. A late payment charge of 1.5% per month (18% annual) of the unpaid balance may be assessed on all accounts over days 60 past due. This agreement is irrevocable. Should any insurance payment be made directly to the insured for money due on this account, the guarantor herein agrees to immediately pay over these funds to Broward Spine Institute, LLC.

I authorize Broward Spine Institute, LLC to release any medical records and/or information acquired in the course of my examination or treatment to my insurance company, primary care physician, or referring physician and to inquire and receive any and all information pertaining to the processing of any and all claims submitted by them on my behalf.

YOU MAY ALSO RELEASE MY MEDICAL RECORDS AND/OR INFORMATION TO:

Two horizontal lines for releasing medical records and/or information to.

Patient/Guarantor Signature: _____ Date: _____

*****Required Information for Minor Patients*****

Guarantor (Print Name): _____ Relationship: _____

Guarantor S.S #: _____ Guarantor D.O.B: _____

Guarantors Signature: _____

Date: _____

3702 Washington Street Suite 101 Hollywood, Florida 33021 Office (954) 272-2225 Fax (954) 272-0554



BROWARD SPINE INSTITUTE



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OFFICE POLICIES

- 1. PLEASE NOTE: *BROWARD SPINE INSTITUTE DOES NOT ACCEPT MEDICAID, THEREFORE YOU WILL BE RESPONSIBLE FOR THE PERCENTAGE YOUR PRIMARY INSURANCE DOES NOT COVER.***
2. Please allow 24-48 hours (not including weekends and holidays) for prescription refills. Please leave your pharmacy telephone number and contact your pharmacy within 24-48 hours.
3. If you have an **HMO** insurance, please allow 7-10 days for authorization before contacting our office.
4. Please schedule a follow-up appointment immediately after any test so the results can be discussed with your physician. Make sure to bring the actual films or CD to your next appointment.
5. If you have an **HMO insurance policy**, you will always **need a referral for each visit**. Please contact your primary care physician for additional visits on your referral the day of your appointment or you will not be seen.
6. There is a \$25.00 charge for any cancelled appointment without 24 hour advance notice.
7. There is a \$25.00 charge for any letter that need to be written or any forms that need to be filled out by your physician, excluding workman's compensation.
8. Please notify the front desk of any changes to your insurance or you will be responsible for all charges incurred.
9. All co-payments or deductibles are **due at time of visit**.
10. When requesting medical records, please allow 48 hours for processing and copying.
11. Remember it is ultimately the patient's responsibility to ensure insurance coverage of all tests and studies ordered by the office.
12. If you have **NO FAULT** insurance and they deny payment, **you will be responsible for all charges**.

Patients Signature: _____

Date: _____

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www.browardSpine.com



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OFFICE POLICIES

Dear Patient:

Please be advised, if your physician recommends you have a diagnostic test (i.e. MRI, Bone Scan, CT Scan, etc.) or surgery, there could be a cost to you. You are responsible for contacting your insurance company to find out if they will pay for your test or surgery and at what facilities you can have the testing done for maximum benefit coverage.

Please let our facility know immediately if the facility at which we are planning to schedule your test is NOT covered by your insurance. We will be contacting your insurance company only to obtain any necessary authorization numbers.

Please contact your physician's secretary at (954) 272-2225 if you have any questions regarding the scheduling of your test or surgery.

I understand I am responsible for picking up the actual films or CD for all tests I have done and I must bring them to my next appointment for the physician to review with me. If I do not bring the films or CD I understand the physician can not see me and the appointment will be rescheduled.

Patient Signature: _____

Date: _____

Your assistance will help us give you the best of care possible with all the resources at our disposal.

Thank you for your cooperation.

From all of us at Broward Spine Institute, LLC.



BROWARD SPINE INSTITUTE



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Dear Patients of BSI,

As a leader in the spine industry and the development of innovative technology, Dr. Marshall E. Stauber, M.D., is constantly working to develop new devices and techniques for the treatment of spine disorders. For our time and recognized expertise in the spine industry we often charge a consulting fee and reserve the right to invest capital in the development of these devices. We are proud of our past work with some of the leading companies in the spine industry. They include Medtronic Sofamor Danek, NuVasive, Kyphon, Zimmer, Stryker, Synthes, Trans 1, and others. We remain completely independent and have no exclusive contract with any company but financially we could benefit by the success or failure of a device. We choose an implant based on the patients indication. At no time do we make our decision to use a device for a financial benefit but rather the reverse, We at BSI have a completely open policy with regard to these incentives. Please feel free to ask us any specific questions regarding them especially if surgery is being contemplated. Please understand that this disclosure at this time is completely voluntary. We at Broward Spine Institute believe that we need to inform our patients of these possible monetary incentives, so that there is a lasting relationship built on honesty.

Thank you for putting the care of you and your loved ones in our hands. We hope to always earn that trust.

Sincerely,

Marshall E. Stauber, M.D

Patient Signature

Date



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AUTHORIZATION TO OBTAIN INFORMATION

I hereby request and authorize _____ to
release my medical records. (Name of Dr. or Organization)

Patient's Name

Patient's Date of Birth

Patient's Identification Number (If known)

Patient's Social Security Number

Patient's Signature

Date

The requested information is to be sent to:

**Broward Spine Institute
3702 Washington St. Suite 101
Hollywood, FL 33021**

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).