BROWARD SPINE INSTITUTE

Daniel A. Wasserman D.O.M,

DOCTOR OF ORIENTAL MEDICINE
DIPLOMATE OF ACUPUNCTURE

Name:______________________ Email:______________________

Address:______________________ ______________________
Street Address City, State, Zip code

Home Phone:______________________ Work Phone:______________________

Cell Phone:______________________

D/O/B:________________ Age:________ Male________ Female________

Single:_____ Married:______ Divorced:_____ Widowed:____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE FILL IN THE FOLLOWING:

Mother's Name:______________________ Father's Name:______________________

Occupation:______________________ Employer:______________________

Address:______________________ ______________________
Street Address City, State, Zip code

Referred By:______________________

I understand that I am ultimately responsible for payment of services rendered. I hereby authorize Daniel A. Wasserman, DOM to release my information including the diagnosis and the records of any treatment or examination rendered by me. I understand and acknowledge that I am responsible for any attorney's fees and cost incurred by the provider for the collection of payments due from me.

Patient's Name (PRINT)______________________ Date:______________

Signature:______________________

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INFORMED CONSENT FOR TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the person named below, for whom I am legally responsible) by the above named licensed physician and/or other licensed physician who now or in the future treat me while employed by, working or associated with or serving as a back up for the treating physician named above, including those working at this office or any office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, homeopathy, manual therapy, cranio-sacral therapy, visceral manipulation, electrical stimulation, Chinese or western herbal medicine, vitamin supplementation, and nutritional counseling and lifestyle, stress and wellness counseling.

I have had the opportunity to discuss with the physician named above and/or with other office personnel the nature and purpose of acupuncture treatment and other procedures.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considering safe in the practice of Chinese Medicine. If I experience any gastro-intestinal upset or allergic reaction to the herbs I will inform physician.

I do not expect the physician to be able to anticipate and explain all risks and complications, and I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels at the time, based upon the facts then known, and is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

If I need to cancel an appointment for any reason, I understand that it is my responsibility to call within 24 hours. Failure to respect this policy will result in a charge of $50 for the space and time reserved for me.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient’s Signature:______________________________ Date:__________________

Are you pregnant? Yes No

To be completed by the patients representative i.e. if the patient is a minor or is physically or legally incapacitated.

Name of Patient (PRINT):______________________________ Date:__________________

Representative Name (PRINT):______________________________

Representative Signature:______________________________

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

** 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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(CONFIDENTIAL)

Patient Name:_______________________________ Today's Date:________________

Age:___________ D/O/B:________________ Last Physical Exam:____________

Reason for today's visit:____

SYMPTOMS Check ☑ symptoms you currently have or have had in past years

GENERAL
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE / JOINT / BONE
Pain, Weakness, Numbness in:
- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

GENITO-URINARY
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL
- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR
- Chest Pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double Vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in the ears
- Sinus problems
- Vision-flashes
- Vision-Halos

SKIN
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN ONLY
- Breast lump
- Erection difficulties
- Lump on testicles
- Penis discharge
- Sore on penis
- Other

WOMEN ONLY
- Abnormal Pap Smear
- Bleeding between Periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period________________

Date of last Pap smear________________

Have you had a mammogram?____________

Are you pregnant?__________

Number of children________

Conditions Check ☑ symptoms you currently have or have had in past years

Aids	Chemical Dependency	High Cholesterol	Prostate Problems
Alcoholism	Chicken Pox	HIV positive	Psychiatric care
Anemia	Diabetes	Kidney Disease	Rheumatic fever
Anorexia	Emphysema	Liver Disease	Scarlet fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid problems
Bleeding disorder	Gonorrhea	Mononucleosis	Tonsillitis
Breast lump	Gout	Multiple sclerosis	Tuberculosis
Bronchitis	Heart disease	Mumps	Typhoid fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal infections
Cataracts	Herpes	Polio	Venereal disease

Medication List medications you are currently taking

____

____

Allergies

____

____

Pharmacy Name:________________________________ Phone Number:________________________

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Health History

FAMILY HISTORY

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following	Disease	Relationship to you
Father						Arthritis	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates:____________________

Serious Illness / injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check ☑ which substances you use and how many you use

	Substance	
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check ☑ if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other
Occupation			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_______________________________ Date:____________________

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Functional Rating index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleep

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, ect.)

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Greatly pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, Etc.)

No pain on long trip	Mild pain on long trip	Moderate pain on long trip	Moderate pain on short trip	Severe pain on short trip

5. Work

Can do Usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% usual work	Can do 25% usual work	Can not work

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6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities

7. Frequency of pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain with heavy weight	Increased with heavy weight	Increased with moderate weight	Increased with light weight	Increased with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain after all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain after any standing

Signature:_____________________________________ Date:______________________

Reviewed by:___________________________________ Date:______________________

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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 ½ 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:

____

____

Patient/Guarantor Signature:________________________ Date:__________________

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

Guarantor (Print Name):______________________ Relationship:____________

Guarantor S.S #:____________________________ Guarantor D.O.B:_________

Guarantors Signature:________________________ Date:__________________

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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 and $50 for any cancelled procedure 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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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.

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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).