



BROWARD SPINE INSTITUTE, LLC

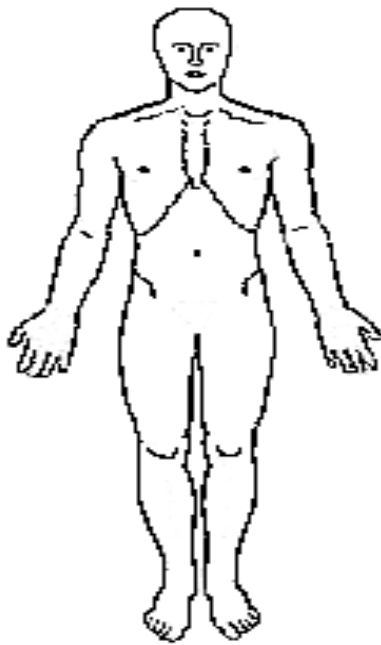
Date:	BSI MR#:	Insurance:	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> PVT <input type="checkbox"/> MCR <input type="checkbox"/> MCD
Last Name:	First Name:	Middle Name:	Day Phone
Evening Phone:	Other Contact Name:	Other Contact Phone:	
Age:	DOB:	Sex:	
Name of Referring Physician:		Phone	Fax
Address:	City:	State:	Zip:
Name of Family Physician:		Phone:	Fax:
Address:	City:	State:	Zip:
<input type="checkbox"/> Physician Referral <input type="checkbox"/> Other Referral Source <input type="checkbox"/> Advertisement <input type="checkbox"/> Other			

***Chief Complaint.** _____

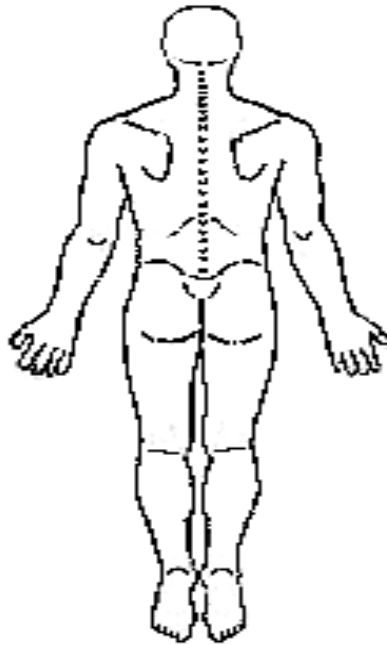
***Duration.** When did your pain start? _____

***Context.** What caused your pain? Accident Cancer Surgery Other Disease or No Obvious Cause (Please Explain): _____

***Pain Location.** Please indicate where you have pain by marking the areas on your body:



FRONT



BACK



LEFT



RIGHT



Below is list of words that might describe your pain. Check all that apply:

- Tender
- Achy
- Stiff
- Sore
- Crampy
- Stabbing
- Sharp
- Pain/sensitive with just light touch
- Shooting
- Electric Shock-Like
- Tingling
- Numb
- Burning or Hot
- Other_____

***Severity.**

Circle the number below to indicate your pain intensity **right now**:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe			Most	

Circle the number below to indicate your **lowest pain intensity over the past week**:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe			Most	

Circle the number below to indicate your **average pain intensity over the past week**:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe			Most	

Circle the number below to indicate your **highest pain intensity over the past week**:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe			Most	

Please check the line below which most accurately describes your average pain intensity:

- Tolerable but pain does not prevent any activities.
- Tolerable and pain prevents some activities.
- Intolerable but pain does not prevent any activities.
- Intolerable and pain prevents activities

***Timing.** When does your pain occur?

- Continuous
- Comes and Goes

***Modifying Factors.**

What makes your pain **worse**?

- Sitting
- Standing
- Walking
- Lying Down
- Coughing/Sneezing
- Bending
- Driving

What makes your pain **better**?

- Sitting
- Standing
- Walking
- Lying Down
- Leaning forward on something to rest such as on a countertop or shopping cart
- Coughing/Sneezing
- Bending
- Driving

Did you have surgery for this pain? Which surgery? How it change the location or quality of the pain? _____



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***Associated Signs/Symptoms.** Please check those which apply:

- Decreased Sleep
- Weakness
- Loss of Control of Urine
- Loss of Control of Stool
- Numbness/Tingling/Pins/Needles

If you had the following tests to evaluate this pain, please indicate the date, where the test was performed, significant results:

Test	Date	Facility/Location of Exam	Results
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> MRI			
<input type="checkbox"/> EMG			
<input type="checkbox"/> Other			

Please indicate if you had any of the following therapies for your pain, who did them, approximate dates, and if the therapy helped: Physician? When? Helped?

- Injections in Muscle (Trigger Point Injections) _____ Yes No
- Epidural Steroid Injections _____ Yes No
- Joint Injections _____ Yes No
- Sacroiliac Joint Injections _____ Yes No
- Facet Injections _____ Yes No
- Medial Branch Blocks _____ Yes No
- All Other Injections (Describe as accurately as possible) _____ Yes No

Physician _____ When? _____ Yes No

Have you have tried?

Has it helped?

Have you have tried?

Has it helped?

- Physical Therapy Yes No
- TENS (Electrical Stim) Yes No
- Acupuncture Yes No
- Laser Yes No
- Chiropractor Yes No

- Massage Yes No
- Traction Yes No
- Biofeedback Yes No
- Pain Coping Training Yes No
- Heat or Ice Yes No



***Past Medical History.** Please check if you have or are treated for any of the following:

	YES		YES
CNS		GI	
Glaucoma		Acid Reflux/GERD	
Stroke		Gastritis	
Migraine Headaches		Ulcers	
Other Headache_____		Liver Disease	
Seizures		Cirrhosis	
Paralysis Level_____		Hepatitis	
Other_____		Irritable Bowel Disease	
CV		Other_____	
High Triglycerides		GU	
High Cholesterol		Acute Kidney Failure	
High Blood Pressure		Chronic Kidney Failure	
Coronary Artery Disease		Kidney Stones	
Angina		Stress Urinary Incontinence	
Heart Attack		Large Prostate	
Arrhythmia		Fibroids	
Heart Failure		Other_____	
Other_____		HEME	
RESP		Hemophilia	
Asthma		von Willebrands Disease	
Emphysema		Use of Blood Thinners	
COPD		Clots in Legs (DVT's)	
I use a CPAP mask		Other_____	
Obstructive Sleep Apnea		INTEG	
Central Sleep Apnea		Skin Condition_____	
Other_____		Psoriasis	
MS		Other_____	
Osteoarthritis		PSY	
Rheumatoid Arthritis		Depression	
Stenosis of Spine		Anxiety Disorder	
Fibromyalgia		Mood Disorder	
Gout		PTSD	
Other_____		Schizophrenia	
ENDO		Other_____	
Diabetes Type <input type="checkbox"/> 1 <input type="checkbox"/> 2		IMMUNE	
High Thyroid		Myasthenia Gravis	
Low Thyroid		Cancer of_____	
Other_____		HIV	
		Other_____	

Other: _____



***Past Surgical History** (please indicate date, type of surgery, and surgeon's name)

Date	Surgery	Surgeon
	<input type="checkbox"/> Neck Surgery	
	<input type="checkbox"/> Back Surgery	
	<input type="checkbox"/> Shoulder Surgery <input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Knee Surgery <input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Other surgery In Area of My Pain _____	
	<input type="checkbox"/> Pacemaker or defibrillator	
	<input type="checkbox"/> All other past surgeries:	

***Allergies**

Are you allergic to any medications?	Please state the reaction that occurs:
Do you have a LATEX allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an IODINE allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

***Family History**

- P.Grandfather: Living Deceased Health/Cause _____
- P.Grandmother: Living Deceased Health/Cause _____
- M.Grandfather: Living Deceased Health/Cause _____
- M.Grandmother: Living Deceased Health/Cause _____
- Father: Living Deceased Health/Cause _____
- Mother: Living Deceased Health/Cause _____
- Brother Sister: Living Deceased Health/Cause _____
- Brother Sister: Living Deceased Health/Cause _____
- Brother Sister: Living Deceased Health/Cause _____
- Brother Sister: Living Deceased Health/Cause _____
- Son Daughter: Living Deceased Health/Cause _____
- Son Daughter: Living Deceased Health/Cause _____
- Son Daughter: Living Deceased Health/Cause _____
- Son Daughter: Living Deceased Health/Cause _____
- _____ Living Deceased Health/Cause _____



***Social History**

Relationship Status:

Married

Divorced

Widowed

Single

Separated

Domestic Partnership

With whom do you live?

Self

Spouse

Children

Parents

Friends

Other: _____

What is your current employment status?

Employed Full-Time

Employed Part-Time

Self-Employed

Retired

Homemaker

Unemployed Due To Pain

Unemployed Due To Other Reason

On Disability

If you are disabled, then do you have an attorney or legal action pending? Yes No

Do you drink alcohol? Yes No If so, how much? _____

Do you smoke? Yes No

Did you quit smoking? Yes No When? _____

If yes to either question above, then _____ Pack(s) Per Day on average for _____ Years

Do you currently or have you ever used recreational drugs? Yes No

If yes, please specify type and last use: _____

Do you currently or have you in the past used prescription "pain killers" more frequently than prescribed on a regular basis? Yes No

Do you find it difficult to control the use of prescription "pain killers"? Yes No



BROWARD SPINE INSTITUTE, LLC

***Review of Systems.** Do you experience any of the following? (Please indicate all that apply):

CONSTITUTIONAL	RESPIRATORY	PSYCHIATRIC
<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Anxiousness
<input type="checkbox"/> Unintentional Weight Loss	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Constant Sadness
<input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Current Suicidal Thoughts
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Cough	<input type="checkbox"/> Past Suicidal Thoughts
<input type="checkbox"/> Malaise	<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Night Sweats	GASTROINTESTINAL	ENDOCRINE
EYES	<input type="checkbox"/> Reflux/Heartburn	<input type="checkbox"/> Hair Has Become Brittle
<input type="checkbox"/> Discharge	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Blindness	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Black Tarry Stool	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive Hunger
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Excessive Urination
<input type="checkbox"/> Need Glasses or Contacts	<input type="checkbox"/> Stool Incontinence	HEME/LYMPH
NEUROLOGICAL	<input type="checkbox"/> Nausea	<input type="checkbox"/> History of Blood Transfusion
<input type="checkbox"/> Headache	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Dizziness	GENITOURINARY	<input type="checkbox"/> Diminished Blood Clotting
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Fainting	<input type="checkbox"/> Urinary Urgency	<input type="checkbox"/> Swollen Lymph Nodes
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Urinary Hesitancy	ALLERGY/IMMUNE
<input type="checkbox"/> Tremors	<input type="checkbox"/> Urinary Retention	<input type="checkbox"/> Recurrent _____ Infections
EARS/NOSE/MOUTH/THROAT	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Food Allergy to Mangos
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Food Allergy to Shrimp
<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Heavy Menstruation	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Ear Infection	MUSCULOSKELETAL	<input type="checkbox"/> Itchy Eyes or Nose
<input type="checkbox"/> Pain in Ear	<input type="checkbox"/> Pain in Joints	<input type="checkbox"/> Hives
<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Pain in Hands	
<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Bone Pain	
<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Swelling in Joints	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Weakness in Arms	
CARDIOVASCULAR	<input type="checkbox"/> Weakness in Legs	
<input type="checkbox"/> Chest Pain	INTEGUMENTARY	
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Rash	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Hives	
<input type="checkbox"/> Decreased Circulation in Legs	<input type="checkbox"/> Excessively Dry Skin	
<input type="checkbox"/> Bluish Discoloration of Hands	<input type="checkbox"/> Ulcers of _____	
<input type="checkbox"/> Short of Breath When Lying Down	<input type="checkbox"/> Lumps	
Below This Point Is For Physician To Fill Out. THANK YOU.		
<input type="checkbox"/> ROS Reviewed With Patient And All Else Negative		



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: _____
(Patient/Parent/Conservator/Guardian)

Date: _____

**

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 acknowledgment at the next available opportunity).

Other Reason: _____



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 fail 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: _____



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: _____



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, LLC

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).