



**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: \_\_\_\_\_



## Daniel A. Wasserman D.O.M, DOCTOR OF ORIENTAL MEDICINE DIPLOMATE OF ACUPUNCTURE

### 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 gastrointestinal 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: \_\_\_\_\_



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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 [X] 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 [X] symptoms you currently have or have had in past years

- Aids, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding disorder, Breast lump, Bronchitis, Bulimia, Cancer, Cataracts

- Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart disease, Hepatitis, Hernia, Herpes

- High Cholesterol, HIV positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple sclerosis, Mumps, Pacemaker, Pneumonia, Polio

- Prostate Problems, Psychiatric care, Rheumatic fever, Scarlet fever, Stroke, Suicide Attempt, Thyroid problems, Tonsillitis, Tuberculosis, Typhoid fever, Ulcers, Vaginal infections, 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

#### Pregnancies

Year of Birth	Sex of Birth	Complications if any

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

Serious Illness / injuries	Date	Outcome

#### Health Habits

Check  which substances you use and how many you use

	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

Table with 5 columns: 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

Table with 5 columns: 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

Table with 5 columns: No pain with heavy weight, Increased with heavy weight, Increased with moderate weight, Increased with light weight, Increased with any weight

9. Walking

Table with 5 columns: No pain any distance, Increased pain after 1 mile, Increased pain after 1/2 mile, Increased pain after 1/4 mile, Increased pain after all walking

10. Standing

Table with 5 columns: No pain after several hours, Increased pain after several hours, Increased pain after 1 hour, Increased pain after 1/2 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 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: \_\_\_\_\_





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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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## 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.*



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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).**