

Are you for (Worker Compensation: YES NO) (Auto Accident: YES NO) (Slip & Fall: YES NO)

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

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

Referring Physician: _____ Primary Doctors Name: _____

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

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

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

Social History: Married Single Divorced Widow Widower Minor

Occupation: _____ Employer: _____

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: _____

Other Conditions: _____

Any Family History of the problems/diseases identified above? Please Identify the family member & the problem or disease.

*Any falls in the past year? _____

Allergies to Medication / Food / Environment: LATEX IODINE NONE

Name of Allergy

Reaction

_____	_____
_____	_____

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

Medication

Dose (mg)

Time per day

_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Surgery/Hospitalizations: NONE

Type of Surgery

Date

_____	_____
_____	_____
_____	_____
_____	_____

EMAIL: _____

PATIENT SIGNATURE: _____

DATE: _____

**BROWARD SPINE INSTITUTE, LLC
REVIEW OF SYSTEMS**

CHECK if are experiencing any of these NOW

GENERAL: Feeling Well Appetite Loss Chills Fatigue Night Sweats Weight Gain Weight Loss

SKIN: Bruising Clamminess Coarse Skin Cold Skin Dryness Excessive Sweating Hair Loss
 Hives Itching Rash Skin Color Change Ulcer

HEENT: Headache Facial Numbness/Tingling Blurred Vision Eye Pain Visual Loss Wears Glasses/Contacts
 Decreased Hearing Ear Pain Ringing in the Ear Vertigo Nasal Congestion Sneezing Sinus Pain
 Sore Throat Dry Mucous Membranes

NECK: Neck Mass Neck Pain Neck Stiffness Neck Swelling Swollen Glands

RESPIRATORY: Cough Difficulty Breathing Difficulty Breathing on Exertion Sputum Production Wheezing

CARDIOVASCULAR: Chest Pain Difficulty Breathing Lying Down Edema Fainting/Black Out Leg Cramp
 Leg Pain/Swelling Night Cramps Palpitations

GASTROINTESTINAL: Difficulty Swallowing Painful Swallowing Heartburn Nausea Vomiting
 Abdominal Pain Bloating Excessive Gas Diarrhea Constipation Change in Bowel Habits
 Incontinence of Stool Pain with Bowel Movement Black, Tarry Stool Bloody Stool

GENITOURINARY: Blood in Urine Change in Bladder Habits Change in Urinary Stream Difficulty with Erection
 Discharge Flank Pain Frequency Hesitancy Impotence Painful Urination Testicular Mass
 Testicular Pain Urethral Discharge Urgency Urinating at night Urine Leak Absence of Menstruation
 Difficulty Emptying Bladder Excessive Menstrual Bleeding Painful Intercourse Painful Menstruation
 Pelvic Pain Stress Incontinence Vaginal Bleeding Vaginal Discharge Vaginal Dryness Vaginal Itching/Burning

MUSCULOSKELETAL: Back Pain Backache Calf Pain Decreased Range of Motion Fasciculations
 Joint Pain Joint Redness Joint Stiffness Joint Swelling Muscle Atrophy Muscle Cramps Muscle Pain
 Muscle Weakness Swelling of Extremities

NEUROLOGICAL: Attention Deficit Decreased Memory Dizziness Fainting Numbness Tremor
 Trouble Walking Unsteadiness Weakness in Extremities Muscle Twitching Tingling

PSYCHIATRIC: Anxiety Depression Disorientation Easily Irritated Fearful Frequent Crying
 Hallucinations Hypersomnia Panic Attacks Suicide ideation Suicidal Planning Trouble Falling Asleep

ENDOCRINE: Cold Intolerance Heat Intolerance Excessive Thirst Excessive Urination Excessive Hunger
 Hair Changes Libido Changes Sexual Dysfunction

HEMATOLOGY: Abnormal Bleeding Anemia Blood Clots Easy Bruising Enlarges Lymph Nodes

HEIGHT _____ **WEIGHT** _____ **PAIN LEVEL 1-10** _____.



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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., GARY B. SCHWARTZ AND VANIA FERNANDEZ 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.

I also give my permission to be treated by the Doctors of Broward Spine Institute LLC, All treatments are explained to me before treatment is considered and I have the right to refuse.

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.

All X-RAYS taken by this office are the property of Broward Spine Institute, LLC. If copies are requested, there will be a charge of \$15.00 per CD for labor and film materials. This charge is to be paid in advance. Thank you for your consideration.

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, instrumentation Representative 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 can revoke this agreement in writing at any time.

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

Referring Physician: _____

Primary Doctors Name: _____

Patient/Guarantor Signature: _____

Date: _____

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

Guarantor (Print Name): _____

Relationship: _____

Guarantor S.S #: _____

Guarantor D.O.B: _____

Guarantors Signature: _____

Date: _____

Initial _____



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OFFICE POLICIES

1. **PLEASE NOTE: BROWARD SPINE INSTITUTE DOES NOT ACCEPT MEDICAID AND OTHER INSURANCES. , THEREFORE YOU WILL BE RESPONSIBLE FOR THE PERCENTAGE YOUR 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. 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.

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. Please allow 7-10 days for authorization on all diagnostic test (i.e. MRI, Bone Scan, CT Scan, etc.) and procedures. **You are responsible for contacting your insurance company to find out if they will pay for your test or surgery. You are responsible for picking up the actual films or CD for all tests. If I do not bring the films or CD I understand the physician can not see me and the appointment will be rescheduled.**
4. There is a **\$25.00** charge for any cancelled appointment without 24 hour advance notice and any letter that need to be written or any forms that need to be filled out by your physician, excluding workman's compensation. If you have a balance of \$150 or more, Payment must be paid before or at the time of your next visit.
5. **Please notify the front desk of any changes to your insurance or you will be responsible for all charges incurred.**
6. All co-payments or deductibles are **due at time of visit.**
7. When requesting medical records, please allow 48 hours for processing and copying. **PATIENTS MUST PICK UP RECORDS OR HAVE THEM SENT TO ADDRESS WE HAVE ON FILE, WE WILL NOT FAX THEM TO PATIENTS.**
8. Remember it is ultimately the patient's responsibility to ensure insurance coverage of all tests and studies ordered by the office.
9. If you have **NO FAULT** insurance and they deny payment, **you will be responsible for all charges.**

Patients Signature: _____

Date: _____

Thank you for your cooperation.

From all of us at Broward Spine Institute, LLC.



BROWARD SPINE INSTITUTE

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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

This authorization is good for 3 (Three) Year. You can revoke this Authorization in writing at any time.

If you have any Question Please Call _____ 954-272-2225
Person Requesting Records

For Dr. _____

- All records for the past _____ year/s
- ALL Consultation and Progress notes**
- Lab Results**
- Radiology Reports**
- EKG Reports**
- Diagnostic Test Reports**
- Medication List**

The requested information is to be sent to:

Attn: _____

Broward Spine Institute
3702 Washington St. Suite 101
Hollywood, Fl 33021
Phone: 954-272-2225
Fax: 954-272-0554

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).



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These tools do not provide legal advice. Consultation with counsel may be appropriate to help identify and pursue claims that should be appealed. For addition information, visit the Private Sector Advocacy website at www.ama-assn.org/go/psa.

Sample Assignment of Benefit

I hereby appoint as my authorized representative, and assign to, Broward Spine Institute, LLC. all my right, title and interest in and to, and relating in and to the recovery of, and any and all health care and/or surgical benefits otherwise payable to me or to which I am entitled for medical treatment, including major medical, rendered by Broward Spine Institute, LLC.

I also specifically authorize my authorized representative to do the following on my behalf:

- 1. File and prosecute any required appeal or grievance with my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative.
2. File any required complaint, appeal or grievance with the state insurance department, Department of Labor, or any other regulatory agency for payment of medical claims submitted by or on behalf of my authorized representative.
3. File any required litigation or arbitration against my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative, and to exert or receive any other rights or benefits under my health plan with respect to the treatment rendered by Broward Spine Institute, LLC. And I specifically authorize my authorized representative to name me and the patient, if I am executing this document on the patient's behalf, as plaintiffs in such litigation or arbitration against my health plan and/or health insurer or otherwise pursue claims on my behalf. I hereby also assign to Broward Spine Institute, LLC. Any right to recover its full billed charges and any expenses and fees incurred for pursuing the claim, as well as all rights, statutory or contractual, to any additional recovery related to my health benefits such as treble damages, punitive damages and/or penalties.
4. Discuss my personal health information with my health plan and/or health insurer.
5. I specifically authorize any law firm appointed by my authorized representative to file litigation or arbitration on my behalf and on behalf of my authorized representative with respect to any or all of the items listed above.

Signature of Patient, Parent (if patient under 18) or Legal Guardian

Date

Print name Patient, Parent (if patient under 18) or Legal Guardian

Date