ORTHO

BROWARD SPINE INSTITUTE, LLC
PAST MEDICAL HISTORY

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 ☐1 ☐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**?_____

Initial_____

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:_____

Initial_____

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_____.

Initial_____

Marshall E. Stauber M.D., Roland D. Kaplan D.O. FAAPM&R, Vania E. Fernandez M.D.,
Gary B. Schwartz M.D., Daniel A. Wasserman D.O.M.

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:_____

Initial_____

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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 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.

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 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_____

BROWARD SPINE INSTITUTE

Marshall E. Stauber M.D., Roland D. Kaplan D.O. FAAPM&R, Vania E. Fernandez M.D.,
Gary B. Schwartz M.D., Daniel A. Wasserman D.O.M.

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.

Initial_____

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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

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).

Initial_____

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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

Initial_____