



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

Last 4 of S.S.# \_\_\_\_\_ Phone # \_\_\_\_\_ Emergency # \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Doctors Name: \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone# \_\_\_\_\_

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

Social History:  Married  Single  Divorced  Widow  Widower  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Last mammogram? \_\_\_\_\_

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: \_\_\_\_\_

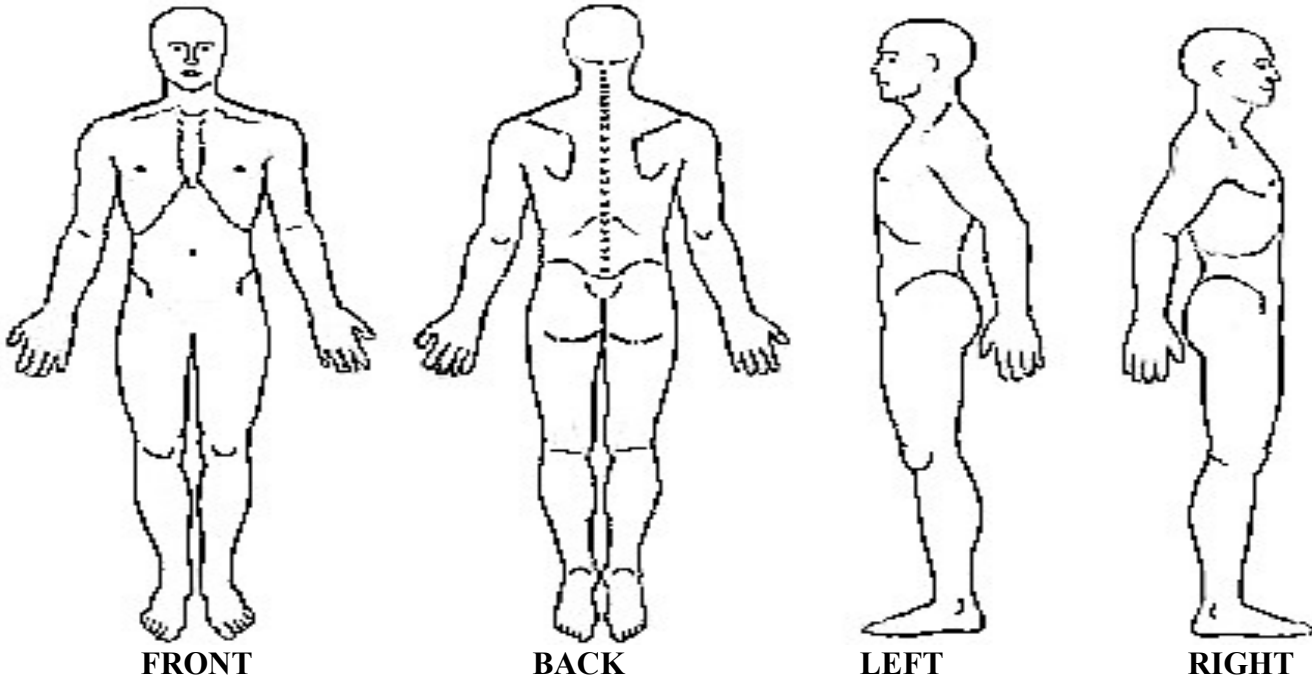
Any Family History of the problems/diseases identified above? Please Identify the family member & the problem or disease.

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

\***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:



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

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

**Severity.** Circle the number that corresponds to your pain over the last week.

	None	(	Mild	)	(	Moderate	)	(	Severe	)	(Most)
<b>lowest</b>	1	2	3	4	5	6	7	8	9	10	
<b>average:</b>	1	2	3	4	5	6	7	8	9	10	
<b>highest</b>	1	2	3	4	5	6	7	8	9	10	

\***Timing.** When does your pain occur? Continuous      Comes and Goes

\***Modifying Factors.**

**What makes your pain *worse*?**

- Sitting    Coughing/Sneezing    Standing    Bending    Walking    Driving    Lying Down

**What makes your pain *better*?**

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

\***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)** \_\_\_\_\_

**Physician** \_\_\_\_\_ **When?** \_\_\_\_\_  Yes  No

**Have you tried within the past six (6) month and continue within the last (6) six weeks?**

- Physical Therapy     Massage     TENS (Electrical Stim     Traction     Acupuncture  
 Over the counter medication \_\_\_\_\_  
 Home Stretching/Exercise     Pain Management     Chiropractor     Heat or Ice

**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
_____	_____
_____	_____
_____	_____

**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** \_\_\_\_\_.



# STOP

Return the top 4 pages to the front desk.  
Then complete.



Marshall E. Stauber M.D., Roland D. Kaplan D.O. FAAPM&R, Vania E. Fernandez 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. 12<sup>th</sup> 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 acknowledgment at the next available opportunity).

Other Reason: \_\_\_\_\_



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

### 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. 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 fail 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 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: \_\_\_\_\_

Guarantors Signature: \_\_\_\_\_

Guarantor D.O.B: \_\_\_\_\_



Marshall E. Stauber M.D., Roland D. Kaplan D.O. FAAPM&R, Vania E. Fernandez 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/No show appointment \$75.00 for procedures** 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.*





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

Dear Patients of BSI,

As a leader in the Spine industry and the development of innovative technology, Broward Spine Institute and Dr. Marshall E. Stauber, M.D., are constantly working to develop new devices, techniques and study protocol for the treatment of spinal disorders. In exchange for our time and recognized expertise in the spine industry we often charge a consulting and/or licensing fees, possible royalties for the use of our designs and we reserve the right to invest capital in the development of these devices. We are proud of our past work with some of the leading companies in the spine industry. They include Medtronic Sofamor Danek, NuVasive, Kyphon, Zimmer, Stryker, Globus, Synthes, Trans 1, and others. We remain completely independent and have no exclusive contract with any company but financially we could benefit by the success or failure of a device. We choose an implant based on the patients indications. At no time do we make our decision to use a device for a financial benefit but rather the reverse. We at BSI have a completely open policy with regard to these incentives. Please feel free to ask us any specific questions regarding them, especially if surgery is being contemplated. Please understand that this disclosure, at this time, is completely voluntary and not required by law. However, we at Broward Spine Institute believe that we need to inform our patients of these possible monetary incentives, so that there is a lasting relationship built on honesty and trust.

I would also like to disclose that I, or my immediate family have partial ownership and/or investment interest in The Miami Medical Center. This is being disclosed in accordance with the requirements of the Medicare program.

Thank you for putting the care of yourself and your loved ones in our hands. We hope to always earn and maintain that trust.

Sincerely,

Marshall E. Stauber, M.D

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Patient Signature

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Date



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

**AUTHORIZATION TO OBTAIN INFORMATION**

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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 Questions, 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**

This authorization is good for 3 (Three) Year. You can revoke this Authorization in writing at any time.  
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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Daniel A. Wasserman D.O.M.

**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](http://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