Marshall E. Stauber M.D., Vania E. Fernandez M.D.,
Daniel A. Wasserman D.O.M.

Name:______________________________ Date of Birth:______________________________

Address:____

Telephone #: ______________________________ Email Address:______________________________

Emergency Contact Name:______________________________Telephone #______________________________

Referring Physician:______________________________Primary Physician Name:______________________________

Pharmacy______________________________Pharmacy Telephone#______________________________

Chief complaint for your visit today?______________________________When Did It Start______________

Is your visit due to: **(Worker Compensation: YES/NO) (Auto Accident: YES/NO) (Slip & Fall: YES/NO)**

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 and or drug abuse past or present? {i.e., marijuana, cocaine, heroin, etc.} [] No [] Yes

If yes, how long and what substance:____

Other Conditions:____

PERSONAL

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:

When and Why ____

PAST MEDCAL HISTORY

Please check if you have or are treated for any of the following:

CNS	**YES**	**GI**	**YES**	**MS**	**YES**
Glaucoma		Acid Reflux/GERD		Osteoarthritis	
Stroke		Gastritis		Rheumatoid Arthritis	
Headaches		Ulcers		Stenosis of Spine	
Seizures		Liver Problems		Fibromyalgia	
CV		Hepatitis		Gout	
High Triglycerides		Irritable Bowel Disease		**PSY**	
High Cholesterol		**GU**		Depression	
High Blood Pressure		Kidney Failure		Anxiety Disorder	
Coronary Artery Disease		Kidney Stones		Mood Disorder	
Heart Attack		Stress Urinary Incontinence		PTSD	
Arrhythmia		Large Prostate		Schizophrenia	
RESP		**HEME**		Other	
Asthma		Hemophilia		**IMMUNE**	
Emphysema		Von Willebrands Disease		Cancer	
COPD		Use of Blood Thinners		HIV	
Obstructive Sleep Apnea		Clots in Legs (DVT's)		Multiple Sclerosis	
ENDO		INTEG		COVID	
Diabetes Type ☐1 ☐2		Skin Condition			
Thyroid Problems					

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

____

____

PAIN

☐Tender ☐Pain/sensitive with just light touch ☐Achy ☐Shooting ☐Stiff

☐Electric Shock-Like ☐Sore ☐Tingling ☐Crampy ☐Numb ☐Stabbing

☐Burning or Hot ☐Sharp ☐Other____
* When does your pain occur? ☐Continuous ☐Comes and Goes

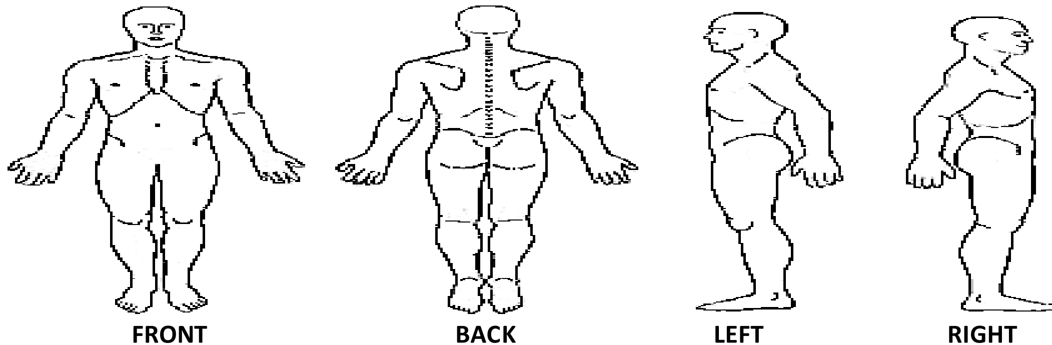
What makes your pain *WORSE*?

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

What makes your pain *BETTER*?

☐Sitting ☐Coughing/Sneezing ☐Standing ☐Bending ☐Walking ☐Driving ☐Lying Down ☐Other

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



TREATMENT

Have you recently had any of the following tests done:

☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ Other

Have you received any of the following treatments in the past 6 months and continued to do in the last 6 weeks?

☐ Physical Therapy ☐ Massage ☐ TENS (Electrical Stim) ☐ Traction ☐ Acupuncture

☐ Home Stretching/Exercise ☐ Pain Management ☐ Chiropractor ☐ Heat or Ice

☐ Over the counter medication____

☐ Injections: ______________________________ By: __________________________ When:________________

☐ CT Scan: ______________________________ By: __________________________ When:________________

☐ MRI: ______________________________ By: __________________________ When:________________

REVIEW OF SYSTEMS

CHECK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING

GENERAL: ___Feeling Well ___Appetite Loss ___Fatigue ___Weight Gain

HEENT: __Headache ___Facial Numbness/Tingling ___Blurred Vision ___Wears Glasses/Contacts __Decreased Hearing

NECK: ___Neck Mass ___Neck Pain ___Neck Stiffness __Neck Swelling __Swollen Glands

RESPIRATORY: ___Cough ___Difficulty Breathing ___Difficulty Breathing on Exertion

CARDIOVASCULAR: __Chest Pain __Difficulty Breathing Lying Down __Edema __Fainting/Black Out

Leg Cramp ___Leg Pain/Swelling __Night Cramps ___Palpitations

GASTROINTESTINAL: __Heartburn __Nausea ___Vomiting ___Abdominal Pain

Diarrhea __Constipation __Change in Bowel Habits

GENITOURINARY: __Blood in Urine __Change in Bladder Habits __Change in Urinary Stream __Flank Pain

Hesitancy __Absence of Menstruation __Pelvic Pain Stress ___Incontinence

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

HEMATOLOGY: __Abnormal Bleeding __Anemia ___Blood Clots ___Easy Bruising __Enlarges Lymph Nodes

HEIGHT___________WEIGHT___________PAIN LEVEL 1-10___________.

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AUTHORIZATION TO OBTAIN INFORMATION

I hereby request and authorize ___________________________________ to release my medical records. **(Name of Dr. or Organization)**

x____ x________________________

Patient's Name Patient's Date of Birth

____ XXX-XX-________________

Patient's Identification Number (If known) Patient's Social Security Number

x______________________________ x____

Patient's Signature Date

The requested information is to be sent to:

Broward Spine Institute
3702 Washington St. Suite 101
Hollywood, Fl 33021
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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**** a 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 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. **PLEASE NOTE: *BROWARD SPINE INSTITUTE DOES NOT ACCEPT MEDICAID AND SOMEOTHER INSURANCES.* THEREFORE YOU WILL BE RESPONSIBLE FOR THE PERCENTAGE YOUR INSURANCE DOES NOT COVER. (PLEASE INQUIRE WITHIN)**

ALL COPAYMENTS OR DEDUCTIBLES ARE DUE AT THE TIME OF VISIT.
IF YOU HAVE AN HMO INSURANCE POLICY, YOU WILL NEED A REFERRAL FOR EACH VISITS.

Please allow 7-10 days to obtain authorization for all diagnostic test (i.e., MRI, Bone Scan, CT Scan, etc.) and procedures. As part of your responsibilities, you will be asked to call your insurance company and find out if the insurance will cover a specific procedure or treatment. You will also be responsible to retrieve any actual films or diagnostic CD images before your appointment date. **Also please notify the front desk of any changes to your address, phone number, pharmacy, and Insurance Plans.**

As part of your relationship with BSI LLC, you can expect that all plan of care and treatment will be explained to you before started and also have the right to refuse.

When requesting medical records, please allow 48 hours for processing and copying. PATIENTS MUST PICK UP RECORDS OR HAVE THEM MAIL TO ADDRESS ON FILE, FAXING RECORDS IS NOT ALLOWED.

All X-RAYS/MEDICAL RECORDS 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.

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**. In the event that I request a release of my information to a third party, not previously considered, a new release form will need to be signed. (I can revoke this agreement in writing at any time.)**

CONCERNING PERSCRIPITON REFILLS, please allow 24-48 hours for them to be processed. ALL requests for medications that need to be monitored may require an office visit for follow-up and/or lab work before being filled. Requests should be made before you run out of your medication so that we have time to approve your refill or notify you that an appointment is needed. Prescription refills will be handled during regular business hours.

CONCERNING MISSING APPOINTMENTS, I am aware that a $25.00 charge will be charged to my account for any same day cancelations, in the event the cancelation is pertaining a procedure appointment $75.00 will be accessed.

CONCERNING A REQUEST FOR FORMS, I am also aware that in the event forms, letters or any notices would be required to be completed by my provider a preprocessed fee will be required prior to its completion.

I hereby acknowledge what has been said above

Signature:____ Date:_________________________________
(Patient/Parent/Conservator/Guardian)

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NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Broward Spine Institute LLC. 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)

ASSIGNMENT OF BENEFITS

I hereby appoint as my authorized representative, and assign to Broward Spine Institute LLC. all the pertinent power and responsibility in relationship to all claim payments, appeals and any necessary avenues to recover payment for services rendered to me. ALL MEDICARE patients must sign an ABN form.

Here by, I also authorize BSI, LLC. To proceed on my behalf while,

1. File any required appeal to my health plan for payment of medical claims submitted on my behalf
2. File a complaint, when necessary, with the State Insurance Department, or any other regulatory agency in regards to claim payment.
3. File any required litigation or arbitration against my health plan and/or health insurer for payment of medical claims submitted byon my behalf, 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. I hereby also assign to Broward Spine Institute, LLC. the 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.

DISCLOSURE

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. 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. We 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

Signature:____ Date:_________________________________
(Patient/Parent/Conservator/Guardian)