BROWARD SPINE INSTITUTE, LLC

Marshall E. Stauber M.D., Barry J. Cutler M.D.

Name/Nombre:_____ Date of Birth /Fecha De Nacimiento:_____

Address/Dirección:_____

Telephone number/ Número de teléfono: _____Cell/Cel: _____

Email Address/Correo electrónico: _____

Emergency Contact Name /Nombre del contacto de emergencia:_____

Emergency contact Telephone #/ # De Telefono del contacto de emergencia_____

Referring Physician/ Médico remitente:_____

Primary Physician Name/Nombre del médico de cabecera:_____

Pharmacy name and tel. #/ Nombre y tel. de farmacia:_____ Address _____

Chief complaint for your visit today? / Razón principal para la cita de hoy? _____

_____. When did it start? / Cuándo comenzó? _____

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

Su visita se debe a: **Compensación al Trabajador: SI o NO** **Accidente De Carro: SI o NO** **Accidente de Resbalon y Caída: SI o NO**

SOCIAL HISTORY/ HISTORIA SOCIAL

[ ] Married/Casado [ ] Single/Soltero [ ] Divorced/ Divorciado [ ] Widow/ Viuda [ ] Widower/ Viudo [ ] Minor/Menor

Occupation/ ocupación:_____Employer/ Empleado:_____

- Do you smoke or Chew Tobacco? /Usted fuma o mastica tabaco? _____
  If yes, how many years? / Si fuma o mastica tabaco, por cuántos años? _____
  How many packs per day? / Cuantos paquetes por dia?_____
- Do you Drink Alcohol? / Usted Bebe alcohol? _____
  If yes, how long and many drinks per day? / Si bebe alcohol, cuantas bebidas al dia?_____
- Is there any substance and/or drug abuse past or present? {i.e., marijuana, cocaine, heroin, etc.} Hay algún abuso de sustancias y/o drogas pasado o presente? {i.e., marijuana, cocaina, heroina, etc.} _____
  If yes, how long, and what substance/ Si hay algún abuso, cual Sustancia?_____

Other Conditions/Otras condiciones:_____

PERSONAL

***Allergies to Medication/Alergias a Medicamentos * Food /Alimentos- * Environment/ Medio ambiente:**

[ ] LATEX [ ] IODINE/YODO [ ] NONE/ NINGUNO

Name of Allergy/ Nombre de la alergia	Reaction/ Reacción

Present Medications/Medicamentos actuales:

Medication/ Medicación	**Dose/ Dosis (mg)**	**Time per day/ Veces al día**

Prior Surgery -Hospitalizations/ Cirugía-Hospitalizaciones previas:

When and Why? / Cuándo y por qué:_____

PAST MEDICAL HISTORY/ HISTORIA MEDICA

***Please check if you have or are treated for any of the following/ Por favor marcar si ha sido tratado por lo siguiente:**

CNS	**YES / SI**	**GI**	**YES/SI**	**MS**	**YES/SI**
Glaucoma		Acid Reflux-GERD/ Reflujo ácido		Osteoarthritis/ Osteoartritis	
Stroke/ Derrame cerebral		Gastritis		Rheumatoid Arthritis/ Artritis reumatoide	
Headaches/ Dolores de cabeza		Ulcers/ Úlceras		Stenosis of Spine/ Estenosis de la columna vertebral	
Seizures/ Convulsiones		Liver Problems / Problema de Hígado		Fibromyalgia/ Fibromialgia	
CV		Hepatitis		Gout/ Gota	
High Triglycerides/Triglicéridos alto		Irritable Bowel Disease/ Enfermedad del intestino irritable		**PSY**	
High Cholesterol/ Colesterol alto		**GU**		Depression/ Depresión	
High Blood Pressure/ Presión alta		Kidney Failure/ Insuficiencia renal		Anxiety Disorder/ trastorno de ansiedad	
Coronary Artery Disease/ Enfermedad de las arterias coronarias		Kidney Stones/ Cálculos renales		Mood Disorder/ Trastorno del estado de ánimo	
Heart Attack/ Infarto		Stress Urinary Incontinence/ Incontinencia urinaria de esfuerzo		PTSD/ Trastorno de estrés postraumático	
Arrhythmia/ Arritmia		Large Prostate/ Agrandamiento de la próstata		Schizophrenia/ Esquizofrenia	
RESP		**HEME**		Other/Otro	
Asthma/ Asma		Hemophilia/ Hemofilia		**IMMUNE**	
Emphysema/ Enfisema		Von Willebrands Disease/ enfermedad de Willebrand		Cancer	
COPD/ Enfermedad cardiopulmunar		Use of Blood Thinners/ Uso de anticoagulantes		HIV/ VIH	
Obstructive Sleep Apnea/ Apnea obstructiva del sueño		Clots in Legs (DVT's)/ Coágulos en las piernas		Multiple Sclerosis	
				Covid	
ENDO	**YES/ SI**	**INTEG**	**YES/ SI**		
Diabetes Type/Tipo □1 □2		Skin Condition/ Condición de la piel			
Thyroid Problems/ Problemas de tiroides					

Any Family History of the problems or diseases identified above? Please Identify the family member & the problem or disease. **/** Algún antecedente familiar de los problemas o enfermedades identificados anteriormente? Por favor, identifique al miembro de la familia y el problema o enfermedad

_____

_____

PAIN/ DOLOR

☐Tender/sensible ☐Pain/sensitive with just light touch ☐Achy/adolorido ☐Shooting/dolor punzante ☐Stiff/rigido

☐Electric Shock-Like/dolor como corriente electrica ☐Sore/adolorido ☐Tingling /hormigeo ☐Crampy/acalambrado ☐Numb /adormesido ☐Stabbing/apunalado

☐Burning or Hot/quemazon ☐Sharp/punzante ☐Other_____

***** When does your pain occur? Cuando tu dolor ocurre es? ☐Continuous/continuo ☐Comes and Goes/viene y va

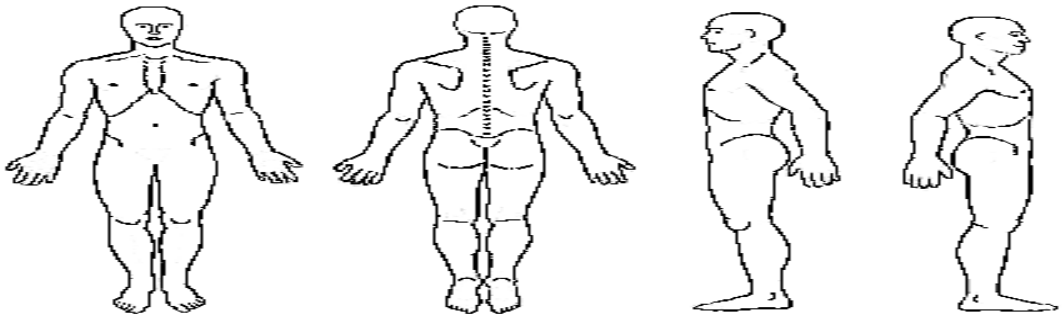
What makes your pain *WORSE*?/ Que hace tu dolor peor?

☐Sitting/sentada ☐Coughing/Sneezing/tosiendo ,estornudando ☐Standing /parada ☐Bending sentada ☐Walking/caminando ☐Driving/manejando ☐Lying Down /acostado

What makes your pain *BETTER*?/que hace que te sientas mejor?

☐Sitting/sentada ☐Coughing/Sneezing/toser, estornudar ☐Standing /parada ☐Bending /doblando ☐Walking/caminando ☐Driving /manejando ☐Lying Down/acostada ☐Other

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



FRONT **BACK** **LEFT** **RIGHT**

TREATMENT

Have you recently had any of the following tests done:/haz tenido recientemente los siguentes test:

☐ 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? /HA

☐ 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/me sentirse bien ___Appetite Loss/Perdida del apetito ___Fatigue/fatiga ____Weight Gain/gane peso

HEENT: __Headache/dolor de cabeza ___Facial Numbness/Tingling/adormecimiento/ hormigeo en la cara ___Blurred Vision /vision borrosa ___Wears Glasses/Contacts/uso lentes/contacto __Decreased Hearing/decrese la audicion

NECK: ___Neck Mass /masa en el cuello ___Neck Pain /dolor de cuello ___Neck Stiffness/ rigidez en el cuello __Neck Swelling/hinchazon en el cuello __Swollen Glands/hinchazon en las glandulas

RESPIRATORY: ___Cough / tos ___Difficulty Breathing dificultad para respirar ___Difficulty Breathing on Exertion/dificultad para respirar con el esfuerzo

CARDIOVASCULAR: __Chest Pain/dolor de pecho __Difficulty Breathing Lying Down/dificultad para respirar acostado Edema /edema __Fainting/Black Out/desmayo

Leg Cramp /calambres en las piernas___Leg Pain/Swelling / hinchazon en las piernas __Night Cramps/ calambres en las noches ___Palpitations/palpitaciones

GASTROINTESTINAL: __Heartburn ___Nausea /nauseas ___Vomiting/vomitos ___Abdominal Pain/abdominal pain

Diarrhea/diarrea __Constipation/estrenimiento __Change in Bowel Habits/cambios en los habitos de ir al bano

GENITOURINARY: __Blood in Urine/sangre en la orina __Change in Bladder Habits cambios en los habitos para orinar Change in Urinary Stream __Flank Pain/dolor en los costados

Hesitancy __Absence of Menstruation/ausencia de la mestruasion __Pelvic Pain Stress dolor en la pelvis Incontinence/incontinencia

MUSCULOSKELETAL: __Back Pain /dolor en la espalda __Backache/dolor en la espalde __Calf Pain/dolor de pantorrilla Decreased Range of Motion/decrese rango de movimiento __Fasciculations/fasciculaciones

Joint Pain/dolor articular __Joint Redness enrojecimiento en las articulacion ___Joint Stiffness rigidez en la articulacion Joint Swelling/inflamacion en articulaciones __Muscle Atrophy/atrofia muscular __Muscle Cramps/calambres Muscle Pain /dolor muscular ___Muscle Weakness /debilidad en los musculos __Swelling of Extremities/hinchazon en las extremidades

NEUROLOGICAL: __Attention Deficit deficit en la atension __Decreased Memory drecrese la memoria __Dizziness /mareos __Fainting /desmayo __Numbness/adormesimiento __Tremor/temblor

Trouble Walking/problemas al caminar ___Unsteadiness/inestabilidad ___Weakness in Extremities/debilidad en extremidades ___Muscle Twitching/espasmos musculares __Tingling/hormigeo

PSYCHIATRIC: __Anxiety/anxiedad __Depression /depresion __Disorientation /desorientacion __Easily Irritated /se irrita facilmente __Fearful/miedo __Frequent Crying/llora con frecuencia

Hallucinations/halucinaciones ___Hypersomnia /hipersomnia __Panic Attacks /ataque de panico __Suicide Ideation/idea de suicidio ___Suicidal Planning planear suicidio __Trouble Falling Asleep/problemas para dormir

HEMATOLOGY: __Abnormal Bleeding /abnormal sangrado __Anemia ___Blood Clots/coagulos de sangre ___Easy Bruising/moretones con facilidad / __Enlarges Lymph Nodes/ganglio linfatico agrandado

HEIGHT/TALLA WEIGHT /PESO PAIN LEVEL/NIVEL DEL DOLOR 1-10 .

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AUTHORIZATION TO OBTAIN INFORMATION

LEAVE BLANK

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.) You may also release my records to:**

_____ _____

CONCERNING PRESCRIPITON 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)