Orthopedic & Spine Injuries

DOCTORS LIEN

Patients Name:_____

Patients Number:_____ **D/O/B**:_____

REF: Medical Reports and Doctors Lien

I do hereby authorize the above Doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sum as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and withhold such sums, including interest from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict, which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is **NOT** contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

It is the intent of the undersigned that this agreement is irrevocable and shall apply to the previously described cause of action whether or not the undersigned should engage co-counsel or substitute any attorneys at any future time and in the event, the undersigned further agrees to immediately advise the doctor's office in writing of said substitution at the time said substitute or agreement of co-counsel should occur.

Patient's Signature:_____ **Date:**_____

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctors above named.

The patient's attorney further agrees to immediately notify the doctor's office in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

Print Attorneys Name:_____ **Phone #**_____

Attorney's signature:_____ **Date:**_____

Address: _____ **Fax#**_____

_____

MUST BE COMPLETE WITH NO CHANGES

Initial_____

PAST MEDICAL HISTORY

Are you here through Auto Accident: YES NO OTHER? _____

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

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

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	
Migraine Headaches		Ulcers		Stenosis of Spine	
Other Headache		Liver Disease		Fibromyalgia	
Seizures		Cirrhosis		Gout	
Paralysis Level		Hepatitis		Other	
Other		Irritable Bowel Disease		**ENDO**	
CV		Other		Diabetes Type ☐1 ☐2	
High Triglycerides		**GU**		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		**PSY**	
Heart Attack		Large Prostate		Depression	
Arrhythmia		Fibroids		Anxiety Disorder	
Heart Failure		Other		Mood Disorder	
Other		**HEME**		PTSD	
RESP		Hemophilia		Schizophrenia	
Asthma		Von Willebrands Disease		Other	
Emphysema		Use of Blood Thinners		**IMMUNE**	
COPD		Clots in Legs (DVT's)		Myasthenia Gravis	
I use a CPAP mask		Other		Cancer of	
Obstructive Sleep Apnea		**INTEG**		HIV	
Central Sleep Apnea		Skin Condition		Other	
Other		Psoriasis			

Social History: [ ] Married [ ] Single [ ] Divorced [ ] Widow [ ] Widower [ ] Minor

Occupation:_____ Employer:_____

When was 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.

_____

_____

***Duration.** When did your pain start? _____

Initial_____

HISTORY OF PRIOR CERVICAL OR LUMBAR INJURY

PRIOR CERVICAL PAIN _____ YES _____ NO

PRIOR CERVICAL INJURY _____ YES _____ NO DATE _____

IF YES HISTORY OF INJURY _____
_____
_____

PRIOR CERVICAL TREATMENT _____ YES _____ NO

PRIOR MRI STUDIES _____ YES _____ NO DATE _____

PRIOR LUMBAR PAIN _____ YES _____ NO

PRIOR LUMBAR INJURY _____ YES _____ NO DATE _____

IF YES HISTORY OF INJURY _____
_____
_____

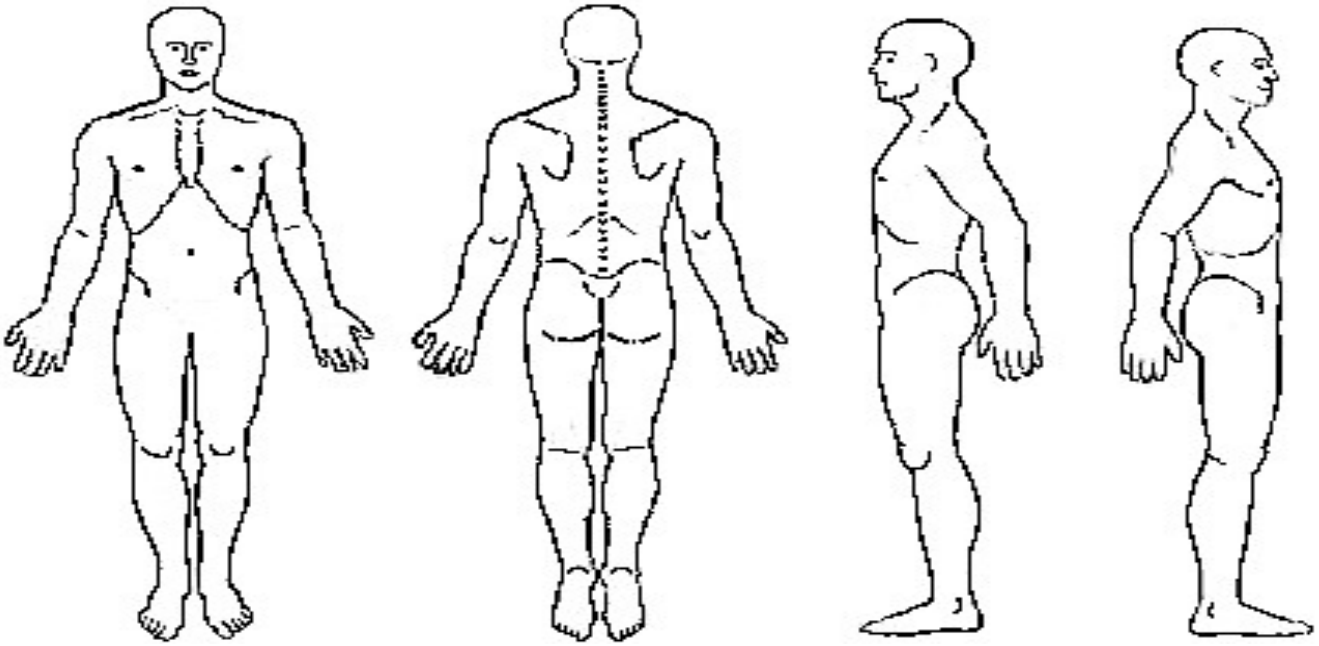
PRIOR LUMBAR TREATMENT _____ YES _____ NO

PRIOR MRI STUDIES _____ YES _____ NO DATE _____

Initial_____

***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:



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

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)
lowest	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
average:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
highest	**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

Initial_____

If you had the following tests to evaluate this pain, please indicate the date, where the test was performed and significant results:

Test	Date	Facility/Location of Exam	Results
☐X-Rays			
☐CT Scan			
☐MRI			
☐EMG			
☐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?

☐Physical Therapy ☐Massage ☐TENS (Electrical Stim ☐Traction ☐Acupuncture
☐Biofeedback ☐Laser ☐Pain Coping Training ☐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:_____

Initial_____

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

Initial_____

NOTICE OF PRIVACY PRACTICES

** ACKNOWLEDGEMENT OF RECEIPT **

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Orthopedic & Spine Injuries 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 Orthopedic & Spine Injuries, 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_____

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., ROLAND D. KAPLAN, D.O., VANIA E. 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.

We are proud to announce Marshall E. Stauber M.D. is now Medical director at Broward Home Care.

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 Orthopedic & Spine Injuries, LLC. If copies are requested, there will be a **charge of $25.00 per film** 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 Orthopedic & Spine Injuries, 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 Orthopedic & Spine Injuries, LLC.

I authorize Orthopedic & Spine Injuries, 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, 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:

_____ _____

_____ _____

Patient/Guarantor Signature:_____ Date:_____

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

Guarantor (Print Name):_____ Relationship:_____

Guarantor S.S #:_____ Guarantor D.O.B:_____

Guarantors Signature:_____ Date:_____

Initial_____

Orthopedic & Spine Injuries
Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

OFFICE POLICIES

1. **PLEASE NOTE: *ORTHOPEDIC & SPINE INJURIES 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.

   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.

5. **Please notify the front desk of any changes to your insurance or you will be responsible for all charges incurred.**

6. All 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:_____

Initial_____

Orthopedic & Spine Injuries

Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

Dear Patients of OSI,

As a leader in the Spine industry and the development of innovative technology, Orthopedic & Spine Injuries 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 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 patient's indications. At no time do we make our decision to use a device for a financial benefit but rather the reverse. We at OSI 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 Orthopedic & Spine Injuries 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.

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

_____ _____

Patient Signature Date

Initial_____

Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

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

The requested information is to be sent to:

ORTHOPEDIC & SPINE INJURIES
3702 Washington St. Suite 407
Hollywood, Fl. 33021

Office: 954-272-0675
Fax: 954-272-0676

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_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize ORTHOPEDIC & SPINE INJURIES to release any medical records and/or information acquired in the course of my examination or treatment to my insurance company, primary care physician, attorney or referring physician via e-mail, fax or U.S. mail. I further authorize them to receive any and all information pertaining to the processing of any and all claims submitted by them on my behalf.

Patient /Guarantor Signature: _____ Date: _____

Initial_____

Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

NOTICE OF PATIENT RESPONSIBILITY

By signing below, I understand that **the Provider will neither bill, nor accept payment from Health Insurance,** including but not limited to, Medicare, Medicaid, or commercial insurance coverage.

If the Provider has a contract with my health insurance carrier, I understand that the Provider will not bill my health insurance carrier. The Provider will rely on Doctors lien, PIP (Personal Injury Protection), Med Pay (Medical Payments Coverage), and if no settlement is reached, the Patient for payment. I am knowingly and voluntarily waiving my rights as a third party beneficiary of any contracts between the Provider and any Health Insurance.

By signing below, I understand that I may be responsible for the above mentioned services.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

Initial_____

Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

ASSIGNMENT OF BENEFITS, AUTHORIZATIONS & DIRECTINS TO INSURER

DATED: _____

For good and valuable consideration, including the agreement of ORTHOPEDIC & SPINE INJURIES (OSI) to accept this Assignment in lieu of demanding full payment for services from the undersigned on the date that each service is rendered, the undersigned patient executes this document hereby assigning to ORTHOPEDIC & SPINE INJURIES (OSI), the right to receive insurance benefits directly from any insurance company that may be obligated to provide such insurance benefits to me or on my behalf, for services rendered by ORTHOPEDIC & SPINE INJURIES (OSI), for a motor vehicle accident that occurred on or about _____, 20____ in which I was involved (the "Accident").

I hereby authorize and assign to ORTHOPEDIC & SPINE INJURIES (OSI), the right to file suit and pursue all legal remedies to obtain payment for services provided to me by ORTHOPEDIC & INJURIES (OSI). This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by ORTHOPEDIC & SPINE INJURIES (OSI) and includes the assignment to pursue declaratory relief or any other legal remedies.

ORTHOPEDIC & SPINE INJURIES (OSI) accepts the aforesaid assignment and hereby notifies any insurer issuing payment that ORTHOPEDIC & SPINE INJURIES (OSI) objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE:
I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to ORTHOPEDIC & SPINE INJURIES (OSI) a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the Accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD:
I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to ORTHOPEDIC & SPINE INJURIES (OSI) a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS:
I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or an my behalf, not to exhaust insurance benefits or coverage until all claims submitted by ORTHOPEDIC & SPINE INJURIES (OSI) have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims.

Initial_____

If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by ORTHOPEDIC & SPINE INJURIES (OSI), or made payment to ORTHOPEDIC & SPINE INJURIES (OSI) at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80 % for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and not to exhaust benefits or coverage by payment of the amount I have hereby requested to be held in escrow. I further authorize and direct the aforesaid insurance company to notify ORTHOPEDIC & SPINE INJURIES (OSI) that benefits have been exhausted except for the amount held in escrow, to enable ORTHOPEDIC & SPINE INJURIES (OSI) to attempt to resolve the disputed claim in a manner acceptable to ORTHOPEDIC & SPINE INJURIES (OSI).

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY:

I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER:

I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to ORTHOPEDIC & SPINE INJURIES (OSI) upon the request of ORTHOPEDIC & SPINE INJURIES (OSI). This authorization includes the authorization to release to ORTHOPEDIC & SPINE INJURIES a copy of any medical examination or evaluation of me requested by any insurance.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF CME OR EUO:

I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to ORTHOPEDIC & SPINE INJURIES of any physical examination or examination under oath of myself that any insurance company may schedule.

TO THE PATIENT: Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any direction or authorization in this document that you do not wish to include, we will remove it from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

ORTHOPEDIC & SPINE INJURIES

_____ _____

Patient or Patient's Guardian Authorized Signatory

Initial_____

Orthopedic & Spine Injuries

Marshall E. Stauber, M.D. Vania E. Fernández, M.D Roland D. Kaplan, D.O.

CONSENT & RELEASE FOR RECORDING/VIDEOTAPING

I _____ understand that Orthopedic & Spine Injuries, LLC,
Patient Name

Dr. Marshall E. Stauber, MD and its employees will be videotaping / recording my surgery / procedure/Office Promotional materials;

_____

Description of Surgery / Procedure/Event

As such, I grant **Orthopedic & Spine Injuries LLC** and/or **Marshall E. Stauber, MD** the right to record my image, likeness, voice and the use of these recordings / videotapes.

I understand that **Orthopedic & Spine Injuries LLC** and/or **Marshall E. Stauber, MD** may: edit, reproduce, and use any material recorded in any way they see fit; release the material recorded to my attorneys for litigation or pre-litigation purposes; assign the right to use the recorded material to third parties.

I relinquish any rights to the recordings / videotapes and understand that the recordings/videotapes may be copied and used by **Orthopedic & Spine Injuries LLC** and/or **Marshall E. Stauber, MD** without further permission.

I understand that I will not be compensated in any way for the recording and/or use of m image, likeness or voice and that this release is irrevocable.

I hereby release **Orthopedic & Spine Injuries LLC** and/or **Marshall E. Stauber, MD**, and any of its associated or affiliated companies, doctors, officers, agents, employees from all claims of every kind on account of such use of the recorded material.

If the patient is under 18, I _____, am the parent/legal guardian of the individual named above, and I have read this release and approve of its terms.

_____
Signature

_____
Print Name

_____
Address

_____
Phone Number

Initial_____

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby asserts:

1. The below patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).

   a) The basis of the opinion for finding an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health, b) serious impairment to bodily functions, c) serious dysfunction of a bodily organ or part

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

_____	_____	_____
Name (Print or Type)	Signature of Medical Provider	Date

The undersigned injured person or legal guardian of such person asserts;

1. The symptoms I reported to the medical provider are true and accurate.
2. I understand the medical provider has determined I sustained and Emergency Medical Condition as a result of the injuries I suffered in the car accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Patient receiving this diagnosis or legal guardian of said injured.

_____	_____	_____
Name (Print or Type)	Signature of injured patient/guardian	Date

Initial_____