BROWARD MEDICAL & REHAB INC.
2607 Polk Street
Hollywood, Florida 33020
(954) 925-7333 Fax: (954) 925-7339

(Please Print)

Welcome to our Office

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ DOB: _____ Gender: ☐ male ☐ female

Race/ Ethnicity: _____ Preferred language: _____

E-Mail Address: _____

***How did you hear about our office:** ☐ Google ☐ Zoc Doc

☐ Website (name of website) _____

☐ Friend (name) _____ ☐ Walk-in ☐ Other

_____

Referring Physician or Hospital: _____ Phone: _____

Family Physician: _____ Phone: _____

Pharmacy of Choice: _____ Pharmacy Phone: _____

(Complete this section only if someone other than the patient is financially responsible)

Responsible Party: _____ Relationship to patient: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ DOB: _____

_____ _____

(Signature of Patient or Responsible Party) **(Date)**

INSURANCE INFORMATION

NAME: _____ **DATE:** _____

PRIMARY INSURANCE

NAME OF INSURANCE CO: _____

POLICY ID NUMBER: _____

GROUP NUMBER: _____

SECONDARY INSURANCE

NAME OF INSURANCE CO: _____

POLICY ID NUMBER: _____

GROUP NUMBER: _____

ATTORNEY INFORMATION (IF APPLICABLE)

NAME OF ATTORNEY: _____

ADDRESS: _____

PHONE: (_____) _____

Did your injury happen on the job? _____ Yes _____ No

Did you report the accident to your employer? _____ Yes _____ No

Did your injury result from an auto accident? _____ Yes _____ No

If yes to any of these, please state date injury occurred. _____

Did you report the accident to your insurance company? _____ Yes _____ No

Our office will file claims for all reimbursable services to both, your Primary and Secondary insurance carriers. Please remember that you are responsible for ALL deductibles, co-pays, and non-covered services amount. See our complete financial policy for details.

Method of Payment for today's visit: CASH ____ CHECK ____ VISA/MC ____ AMEX ____

_____ _____

Signature of Patient of Responsible Party **Date**

DATE_____

Name: (Nombre) _____

Age: (Anos) _____ **Height: (Altura)** _____ **Weight: (Peso)** _____

CHIEF COMPLAINT: (Queja Principal)

Why are you seeing the doctor: _____

PAST MEDICAL HISTORY: ☐ None

☐ Asthma ☐Colitis ☐ Bleeding Disorder ☐ Blood Clot ☐ Ulcers ☐ Diabetes ☐ Stroke ☐ Gout ☐ Fractures

☐ Arthritis ☐ High Blood Pressure ☐ Glaucoma ☐ Migraines ☐ Heart Disease ☐ Lung Disease ☐ Kidney

Disease ☐ High Cholesterol ☐ Prostate Enlargement ☐ Diverticulosis ☐Hepatitis ☐ Nerve Disease ☐ HIV/

AIDS ☐ Cataracts ☐ Osteoporosis ☐ Tuberculosis

☐ Cancer (if yes, what type): _____

☐ Other: _____

PAST SURGICAL HISTORY: (Antecedentes quirurgicos pasado) ☐ None

☐ Hysterectomy ☐ Gall Bladder ☐ Heart Valve ☐ C-Section ☐ Breast ☐ Pacemaker ☐ Hernia

☐ Back/ Neck ☐ Appendectomy ☐ Stomach/ Colon ☐ Prostate ☐ Heart Bypass ☐ Tonsillectomy

☐ Cataracts ☐ Hand ☐ Cancer (location) _____
☐ Joint Replacement (location) _____
☐ Arthroscopy (location) _____
☐ Other: _____
Have you ever had General Anesthesia? ☐ Yes ☐ No
Have you ever had problems with anesthesia? ☐ Yes ☐ No
If yes describe: _____

FAMILY HISTORY: Mother ☐ alive ☐ deceased Father ☐ alive ☐ deceased

SOCIAL HISTORY: __ Single __ Married __ Divorced __ Separated __ Widowed

__ Work at Home __ Student __ Unemployed __ Retired __Occupation: _____

***Smoke Cigarettes** ☐ yes ☐ no ***Drink Alcohol** ☐ yes ☐ no ***History of Substance Abuse** ☐ yes ☐ no

MEDICATION ALLERGIES: (Alergias a los medicamantos)
☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Tape
Other: _____

FOOD ALLERGIES: (Alergias a los alimentos)

_____

CURRENT MEDICATIONS: (Medicamentos acutuales) *Include Vitamins and Supplements*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS: (Revision de Sistemas) (Circle all that apply)

General: chills, weight loss, night sweats, fever, weight gain, appetite loss, excessive perspiration, feeling sick, fatigue.

Eyes: Double vision, halos around lights, discharge vision loss- 1 eye, blurring, eye irritation, vision loss 2 eyes, light sensitivity, eye pain.

ENT: earache, ringing in ears, ear discharge, nosebleeds, hoarseness, decreased hearing, nasal congestion, sore throat.

Cardiovascular: shortness of breath with exertion, swelling of hands or feet, leg cramps with exertion, bluish discoloration of lips or nails.

Respiratory: excessive sputum, cough, sleep disturbances due to breathing, wheezing, excessive snoring, coughing up blood.

Gastrointestinal: excessive appetite, nausea, gas, indigestion, diarrhea, vomiting, constipation, difficulty swallowing, vomiting blood, yellowish skin color, dark tarry stools, abdominal pain, change in bowel habits, bloody stools.

Musculoskeletal: muscle cramps, joint pain, stiffness, muscle weakness, joint swelling, back pain, muscle aches.

Genitourinary: painful urination, trouble starting urinary stream, pelvic pain, blood in urine, inability to empty bladder, genital sores, urinary urgency, inability to control bladder, missed periods, urinary frequency, night time urination, excessively heavy periods.

Skin: rash, itching, suspicious lesions, changes in skin color, dryness, poor wound healing, changes in nail beds.

Neurologic: headaches, falling down, tingling, poor balance, fainting, disturbances in coordination, numbness, memory loss, difficulty with concentration, tremors, weakness, sensation of room spinning.

Endocrine: heat intolerance, excessive thirst, cold intolerance, excessive hunger, excessive urination.

Home/ Lymphatic: abnormal bruising, bleeding, skin discoloration, enlarged lymph nodes.

Patient Signature: _____ Date: _____

BROWARD MEDICAL AND REHAB

2607 POLK STREET
HOLLYWOOD, FLORIDA 33020
PH: 954-925-7333 FAX: 954-925-7339

CONTRACT FOR PRESCRIPTION CONTROLLED SUBSTANCE MEDICATION

Controlled substances (narcotics, tranquilizers and barbiturates) and all prescription medications can be very useful in the treatment of pain. Unfortunately, they also have a high potential for abuse and misuse and are closely supervised by the local, state and federal government.

I agree to enter into the following contract with Robin G. Simon, D.O.:

1. I am responsible for my controlled substance and all prescription medications. If the prescription or medication is lost, misplaced, stolen, or I use it sooner than prescribed, I understand that it will **not** be replaced.
2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from Robin G. Simon, D.O. The exception would be if I were hospitalized and under the care of another physician.
3. Refills of controlled substance and all prescription medication:
   A. Will be made during office hours only, 9:00 am to 5:00 pm Monday through Friday. Refills will **not** be made at night, on holidays or weekends.
   B. Will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   C. Will not be made as an "emergency". I will call at least 12 to 24 hours ahead of time if I need assistance with a controlled substance and prescription medication.

I understand that if I violate any of the above conditions, my relationship as a patient with Robin G. Simon, D.O. may be terminated. I understand that I may be reported to the Drug Enforcement Authorities, other physicians and local medical facilities.

Patient Signature: _____

Print patient's Name: _____

Witness: _____

Date: _____

BROWARD MEDICAL AND REHAB

2607 POLK STREET

HOLLYWOOD, FLORIDA 33020

PH: 954-925-7333 FAX: 954-925-7339

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

PURPOSE:

These drugs are used for the treatment of inflammation, swelling, stiffness and joint pain caused by arthritis and other conditions. They do not cure arthritis and will help only as you take them. Some of these medications are for gout, strains, bursitis and tendinitis, as well as other conditions.

PRECAUTIONS:

1. If you have bleeding problems, a stomach ulcer or are taking anticoagulants, tell your doctor. DO NOT take if pregnant or breast-feeding.
2. If you are going to have any type of surgery or dental procedure, tell your physician you are taking this drug. It may affect blood clotting.
3. Since this medicine may cause some people to become drowsy, make sure you know how you react to it before you drive, use machines, or do other jobs that require you to be alert.

SIDE EFFECTS:

Along with its needed effects a medicine may cause some unwanted effects. Check with your doctor if any of the following side effects occur:

Generalized skin rash, headaches, dizziness, nausea and/or vomiting, nervousness, drowsiness, depression, diarrhea, and ringing in the ears, fluid retention, or unexplained fever.

Other side effects not listed above may also occur in some patients. If you notice any other effects check with your doctor.

ADDITIONAL INFORMATION:

1. If this drug causes stomach upset, it may be taken with meals or milk.
2. Aspirin, Advil, or any Ibuprofen should not be taken with this medicine. Tylenol can be taken with anti-inflammatories.
3. If you miss a dose of this medicine and remember within 1 hour or so of the missed dose, take it as soon as possible. Then go back to your regular dosing schedule. DO NOT double dose.
4. If you experience a rise in blood pressure discontinue this medication and check with your family physician.
5. These drugs may take a few days to a few weeks before you will feel their full effects.
6. Although these drugs fall into the same broad classification, one drug may be more effective for you. Your physician will check your progress at regular intervals and decide what is best for you.

I have read the above information. My signature indicates that I understand all of this information.

Patient's signature: _____

Broward Medical and Rehab, Inc.
2607 Polk Street
Hollywood, Florida 33020
Ph.: 954-925-7333 Fax: 954-925-7339

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES & TREATMENT: I consent to treatment, diagnostic and/ or therapeutic services as ordered and/ or provided by ***Dr. Robin Simon*** or ***Dr. Bruce Mark*** as physicians of **Broward Medical and Rehab, Inc.** and their designee(s).

FINANCIAL AGREEMENT: The undersigned individually obligates him/her and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the minimum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/ or collection agency fee and expenses. The undersigned understands that **Broward Medical and Rehab** has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

ASSIGNMENT OF BENFITS: In the event that I am entitled to physician benefits of any and all types, I assign such benefits to **Broward Medical and Rehab** for services rendered to me. I authorize payment directly to **Broward Medical and Rehab** of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/ liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's Compensation and authorizes Broward Medical and Rehab to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION: I authorize **Broward Medical and Rehab** to release all or part of my medical record/ information when required or permitted by law of government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICATION: I understand that before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in **Broward Medical and Rehab**, including physician services. I authorize any holder of medical or other information about me to release to the centers of Medicare & Medicaid services or its agents any information needed to determine these benefits or benefits for related services.

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by or in **Broward Medical and Rehab** for any services furnished to me by

that physician/ supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

CONSENT FOR MEDICAL SERVICES & TREATMENT: I have been provided with a copy with a copy of the SMHCS Notice of Privacy Practices that describes how **Broward Medical and Rehab** may use and disclose my health information and also describe my rights regarding my health information.

EVALUATION OR SERVICES AND FOLLOW-UP

I give permission for **Broward Medical and Rehab**, Inc. and/ or its agent(s) to contact me for the purpose of the evaluating the services rendered to me.

YES _____ **NO** _____

The undersigned certifies that he/ she has read and understands the above, fully accepts all specified terms therein, and has received the information on patients' rights, including the mechanism for initiation, review, and resolution of complaints and copy of the SMHCS Notice of Privacy Practices.

Signature of Patient of Legally Authorized Representative: _____

Print Name of Patient or Legally Authorized Representative: _____ **Date:** _____

Signature of Guarantor of Payment: _____

Print Name of Guarantor of Payment: _____ **Date:** _____

Signature of Witness: _____

Print Name of Witness: _____ **Date:** _____

BROWARD MEDICAL & REHAB, INC.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

Name of Patient/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip _____

AUTHORIZES MY CURRENT PHYSICIAN:

Physician Name _____

Street Address _____

City, State, Zip _____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

ROBIN SIMON, D.O.
Physician Name/Self

2607 POLK STREET
Street Address

HOLLYWOOD, FLORIDA 33020
City, State, Zip

INFORMATION TO BE RELEASED:

I hereby authorize you to release **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for information pertaining to:**

____ Sexually transmitted disease
____ Treatment of alcohol or substance abuse
____ Records from other facilities/providers
____ Testing or treatment of HIV/AIDS
____ Communication between patient and psychotherapist for mental health treatment

For the Following Date(s): _____

PURPOSES FOR NEED OF DISCLOSURE: (check one)

____ Further Medical Care
____ Other (Specify): _____
____ Insurance/Eligibility

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand the Tenet Florida Physicians will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Tenet Florida Physicians will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so)

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six months from the date signed.

Distribution of Copies: Original to provider; copy to patient; copy to accompany released records

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient;

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI maybe disclosed to the individual(s) listed below until you notify us otherwise in writing.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

Employee signature

Date