TODAY'S DATE: ______________________

PATIENT INFO			
First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yy): _ _/_ _/_ _	Social Security No.: __ __ __ - __ __ - __ __ __ __		
Sex: ☐ Male ☐ Female	Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced		
Home Address:	Apt No.		
City:	State:	Zip:	County:
(Please include all phone numbers.) Home Phone: Cell:	Email:		
EMPLOYER INFO			
Company /Employer Name:	Job Title / Description:		
Business Address:			
EMERGENCY INFO			
Contact Name:	Relationship:	Phone:	
MISCELLANEOUS INFO			
Is patient here as a result of an accident: ☐ Yes ☐ No	Date of Accident: (mm/dd/yy): _ _/_ _/_ _		
Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Sports ☐ Other (pls. specify) ____________			
PRIMARY CARE INFO			
Primary Care Physician (Name):	Phone:		
INSURANCE/PAYOR INFO (Please provide copy of insurance card and picture ID)			
Primary Insurance Company:	Phone:		
Adjuster Name:	Policy Number:		
Claim Number:	Group Number:	ID Number:	
Secondary Insurance Company:	Phone:		
Adjuster Name:	Policy Number:		
Claim Number:	Group Number:	ID Number:	
LEGAL REPRESENTATION INFO			
ATTORNEY:	LAW FIRM:		

I hereby certify that the information provided above is true and correct to the best of my knowledge.

Patient's Name: ____

If minor, name of Parent/Legal Custodian: ____

Signature ___________________________________ Date: ______________________________

AIP FORM WPT- 1001

ABSOLUTE INJURY & PAIN PHYSICIANS

Assignment of Insurance Benefits, Direction to Pay and Authorization for Insurance Information

I, ________________________________hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and to directly pay RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS for any and all professional, medical, and/or rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS in relation to any health insurance, motor vehicle insurance, and/or any other insurance that may provide me with coverage for services performed by RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS.

This assignment of insurance benefits is provided so that RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS may attempt to collect any unpaid or overdue insurance benefits from all insurance carriers. This includes the assignment of any cause of action that might accrue against any insurance carrier for its failure to timely pay for services rendered to me by RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS. Such assignment is given in consideration of RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS accepting me as a patient and rendering professional, medical and/or rehabilitative services.

I authorize any holder of insurance information about me to release such information to RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS as requested to determine the insurance benefits or to assist in the collection of payment for services. I authorize RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided to me by RIVER CITY MEDICAL ASSOCIATES, INC. d/b/a ABSOLUTE INJURY AND PAIN PHYSICIANS that may not be paid in full under the benefits of my insurance policies and/or that my insurance policies may deny or refuse to pay. I expressly understand that I am responsible to pay for these services in addition to any amounts outstanding for co-payments, deductibles or non-covered services.

A copy of this agreement will be as valid as the original.

I have read and I do understand this Assignment of Benefits thoroughly.

Patient's Name: ____

Patient's Signature: ____ Date: _______________

If patient is a minor:

Name of Parent or Legal Guardian: _____________________________________

Signature of Legal Guardian: ________________________________ Date: _______________

AIP FORM WPT-1002

RIVER CITY MEDICAL ASSOCIATES, INC. d.b.a. Absolute Injury and Pain Physicians
MAIN OFFICE: 6947 Merrill Rd., Jacksonville, FL 32277 | Ph (904) 743-2222 F (904) 743-3087

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: ____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street Address, City, State, Zip Code

RE: Patient Name: ____

Date of Birth: ________________ Social Security Number: _________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _________________ to _________________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:

____.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

______________________________	______________________________
Name of Representative	Representative Capacity (e.g. attorney, records requestor, agent, etc.)

____

Street Address, City, State, Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

______________________________________	______________________
Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi))	Date
______________________________________	______________________
Name of Legally Authorized Representative to Patient	Relationship
______________________________	______________________
Witness Signature	Date

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Get Your Life Back!

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print):	
Signature:	Date:
(If patient is minor, please print) Name of Parent, Guardian or Patient's Legal Representative:	
Signature:	Date:

List below the **names of people** to whom you authorize the Practice to release Patient Health Information (PHI), and your relationship with them:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

*** Notice of Privacy is available on the website as well as at the front desk of each location.**

X-RAY / TREATMENT CONSENT FORM

Patient consent to X-rays

I, _________________________ authorize the performance of diagnostic X-ray examination of myself, which the above doctor or his/her associates may consider necessary or advisable in the course of my examination and treatment.

Signed______________________________ Date_____________________

Non-pregnancy verification

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform diagnostic X-ray examination. I have been advised that X-rays can be hazardous to an unborn child.

Date of last menstrual period _______________________________

Signed______________________________ Date_____________________

Consent to X-rays/treat a minor

I, ________________________, authorize the performance of treatment and/or diagnostic X-rays examination of my child or ward, _______________________, which the above doctor and his/her associates consider necessary or advisable in the course of examination and treatment. The patient is a minor, _________ years of age.

Signed______________________________ Date_____________________

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REVIEW OF SYSTEMS – ADULT

Please take a moment to complete the following. Check the ones that you have experienced in the last three (3) months. **Explain** if you deem necessary.

	YES	NO	
GENERAL	☐	☐	Allergies to medications; please list:
	☐	☐	Recurrent fever or chills
	☐	☐	Unintentional weight loss
	☐	☐	Recurrent fatigue or malaise
SKIN	☐	☐	Rash or skin color changes Recurrent fever or chills
	☐	☐	Jaundice (yellowing of the skin or eyes)
	☐	☐	Moles that are changing color or size
HEENT	☐	☐	Headaches that are new or changing in frequency or severity
	☐	☐	Hearing changes
	☐	☐	Visual changes (if YES, are you seeing an eye doctor? ☐ Y ☐ N)
	☐	☐	Non-healing mouth sores
	☐	☐	Swollen glands or neck lumps
	☐	☐	Hoarseness
RESPIRATORY	☐	☐	Cough that is chronic, produces phlegm or is changing
	☐	☐	Difficulty breathing
	☐	☐	Wheezing
	☐	☐	Smoking, or exposed to 2nd hand smoke
CARDIAC	☐	☐	Chest pain or pressure
	☐	☐	Shortness of breath with normal activity
	☐	☐	Difficulty breathing when lying flat
	☐	☐	Shortness of breath that wakes you from sleep
	☐	☐	Palpitations (sensation of heart beating in your chest)
	☐	☐	Swelling in the ankles
GASTRO-INTESTINAL	☐	☐	Difficult or painful swallowing
	☐	☐	Recurrent nausea or vomiting
	☐	☐	Recurrent diarrhea or constipation
	☐	☐	Recurrent abdominal pain or cramping
	☐	☐	Bloody or black bowel movements
GENITOURINARY	☐	☐	Pain with urination
	☐	☐	Dark or reddish urine
	☐	☐	Involuntary loss of urine
	☐	☐	Decreased force of urine stream or difficulty starting urine
	☐	☐	Problems achieving or maintaining erections
MUSCULO-SKELETAL	☐	☐	Painful joints (if so, which one?)
	☐	☐	Swollen joints
	☐	☐	Morning joint stiffness (if so, how long does it last)
NEUROLOGIC	☐	☐	Frequent dizziness
	☐	☐	Fainting
	☐	☐	Weakness in arms or legs
	☐	☐	Numbness or tingling in arms or legs
	☐	☐	Un-coordination or loss of balance

*******Turn and complete second page*******

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REVIEW OF SYSTEMS – ADULT p. 2			
Please take a moment to complete the following. Check the ones that you have experienced in the last three (3) months. **Explain** if you deem necessary.			
	YES	**NO**	
PSYCHOLOGIC	☐	☐	Feeling unsafe at home
	☐	☐	Anxiety
	☐	☐	Little interest or pleasure in doing things
	☐	☐	Feeling down, depressed or hopeless
	☐	☐	Suicidal thoughts
	☐	☐	Social problems that you feel interfere with your mental or physical health
			IF YOU USE ALCOHOL or other RECREATIONAL DRUGS
	☐	☐	Tried to cut down or change your use
	☐	☐	Angered or annoyed by people confronting your use
	☐	☐	Felt guilty about your use or consequences of your use
	☐	☐	Used first thing in the morning as an "eye opener"
INFECTIONS	☐	☐	Feel at risk for HIV infection
	☐	☐	Exposed to or treated for tuberculosis
	☐	☐	Blood transfusion
	☐	☐	Recurrent night sweats
	☐	☐	Sexually transmitted diseases
ENDOCRINE	☐	☐	Frequent urination (if so, how many times do you get up at night to urinate?)
	☐	☐	Increased thirst
	☐	☐	Skin, hair or fingernail changes
	☐	☐	Hot or cold intolerance
GYNECOLOGIC (female)	☐	☐	Still having menstrual periods. If YES, when was your last period? ___________
			If YES, at what age did your periods stop? _________
	☐	☐	Vaginal bleeding differing from your regular menstrual flow
	☐	☐	Abnormal vaginal discharge
	☐	☐	Painful intercourse
	☐	☐	New breast lumps
	☐	☐	Abnormal pap smears. Date of last pap smear: ___________
	☐	☐	Abnormal mammograms. Date of last mammogram: ______________
PREVENTION SCREENING	☐	☐	Exercise on a regular basis (at least 3x a week)
	☐	☐	Believe you eat a varied, balanced diet
	☐	☐	Had a tetanus shot within the last 10 years. If so, when: ______________
	☐	☐	Had the pneumonia vaccine (Pneumovax). If so, when: ________________
	☐	☐	Had a sigmoidoscopy or colonoscopy. If so, when: _______________
	☐	☐	See other doctors on a regular basis. If so, when: _______________
Name of Patient:			Date:
Provider Name and Signature:			

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