Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

Patient Information
Name:
Sex: Male Female Age:
Home Address:
City, State:
Zip Code:
e-mail:
Home Telephone #:
Cellular Telephone #:
Social Security #:
Date of Birth:
Marital Status:
Primary Care Physician
Name:
Doctor's phone #:
Office Address:
City, State:
Zip Code:
Patient's Occupation
Employer:
Address:
City, State:
Zip Code:
Work Telephone #/ ext:

For Office Use:	MR#
Health Insurance Information	
Primary Insurance Carrier:	
Insurance Carrier's Phone #:	
Policy #:	
Group #:	
Name of Insured:	
Insured's Date of Birth:	
Insured's Social Security #:	
Patient's Relationship to Insured:	
Secondary Insurance:	
Secondary Policy #:	
Secondary Group #:	
Is this an AUTO or WORKMAN'S COMP case? YES NO	
If so, Case #:	
Date of Injury:	
Case Manager's Name:	
Case Manager's Telephone #:	
In Case of Emergency, Notify:	
Name:	
Relationship to Patient:	
Home Address:	
City, State:	
Zip Code:	
Home Telephone #:	
Cellular Telephone #:	

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

RIVERSIDE PAIN PHYSICIANS, P.L.

Practice Policies

1. Appointment Confirmation/Cancellation Policy
   We will call 1-2 days prior to your appointment to remind you of the date and time. If we leave a message asking you to call, please be sure to call us at 904-389-1010 to confirm. If we do not hear from you within 24 hours of your appointment, we may make that time available to other patients and you may be asked to reschedule.

2. Controlled Substance Prescription Policy
   Prescriptions for medications will be given to you only during a scheduled visit. We cannot provide refills over the phone; Instead we ask that you schedule a brief refill visit with us. See narcotic agreement for more information.

3. Clinical Questions
   Always feel free to contact us with concerns or questions. You may speak with our receptionist about appointments or administrative matters, or our office manager about financial matters. Medical questions are directed to our nurse manager. Any question that requires the advice of a physician should be addressed in person with an appointment.

4. Disability Forms, etc.
   We usually charge a fee for time spent filling out special forms. The fee depends on the length and complexity of the form, and ranges from $25-$45. This fee is not submitted to insurance companies for payment and is paid by the patient when the form is submitted to us.

5. Medical Records Release & Copying Fee
   We require a written release from the patient to authorize outbound transmittal of medical records by mail, courier, or facsimile. There is usually a charge associated with document preparation and copying; you may ask for an estimate.

6. Your Initial Evaluation Visit
   You should understand that this is a time for us to become acquainted with one another's philosophy for pain management. We may not agree with the treatment or prescriptions that you have received so far, and *we may or may not wish to continue certain prescription medications (including narcotics)*. If, after discussing your case with you, we decide that a certain injection would be appropriate, you should expect to return for the procedure.

I have read the above and understand Riverside Pain Physician's practice policies.

Signed_____Date_____

Patient Name: _____

Date of Birth: _____

RIVERSIDE PAIN PHYSICIANS

Riverside Pain Physicians FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care, and to working with you to utilize health care dollars wisely. As part of this commitment, we provide several services as a courtesy to you, as outlined below:

If you have:	You are responsible for:	As a courtesy to you, our staff will:
An HMO (Including Medicare HMOs) with whom we are contracted	1) Obtaining a referral from your primary care physician 2) Payment of Co-pays and Deductibles at the time of service	File an insurance claim on your behalf
An HMO with whom we are not contracted	Understanding your co-pay responsibility	File an insurance claim on your behalf
Point of Service (POS), Preferred Provider Organization (PPO) Plan, or Indemnity Plan with whom we are contracted	1) Obtaining a referral from your primary care physician (if applicable) 2) Payment of the patient responsibility at the time of service	File an insurance claim on your behalf
Commercial, PPO, or any Plans with whom we are not contracted	Payment of the patient responsibility at the time of service based on out of network benefits. Many insurance companies base their payment on "usual and customary charges." The patient may be responsible for any amount above "usual and customary."	File an insurance claim on your behalf
Medicare without secondary "Medigap" policy	Payment in full of deductible and 20% coinsurance at time of service	File a Medicare claim on your behalf
Medicare with secondary policy	Payment of remaining deductible and coinsurance	File a Medicare claim on your behalf, file a secondary insurance claim
Secondary Insurance	Supply policy information, and pay coinsurance and deductible amounts	File secondary insurance claims on your behalf
No Insurance	Payment in full prior to service	We offer a discount from standard fees.
Workers Compensation	Provide us with the accident date, claim number, attending physician, employer, employer's address and adjuster information.	File an insurance claim on your behalf
Accident Related (non Workers' Compensation), PIP, or LOP	Providing correct information regarding accident, attorney and legal case.	File claims to your attorney or other responsible party.

As a courtesy, we will also call your insurance company ahead of time to determine eligibility, deductibles, coinsurance, and obtain approval. This does not guarantee reimbursement. The patient or "responsible party" remains fully responsible for eligibility, and for the entire amount of the bill.

Billing

The bill from the physician(s) includes professional fees for service provided. It does not include hospital or surgery center charges, if applicable. You will continue to receive statements as long as there is a balance on your account. You remain fully responsible for the entire amount of the bill. We file insurance as a courtesy; this does not release the patient from ultimate financial obligation. Your account may be sent to a collection agency if not paid in full within 180 days (6 months). If sent to collections, a collection fee of an additional 30% will be added to your bill. To avoid this, please call the billing company and make prior arrangements for payment.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, applicable co-payments, and deductibles are my responsibility. I understand that failure to pay my account may result in my account being forwarded to a collection agency and restrictions on scheduling appointments.

I authorize my insurance benefits be paid directly to the provider.

I authorize the provider to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

_____ _____ _____

Patient Signature Printed Name Date

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstanding about certain medicines that you will be taking for pain management. This agreement is intended to protect your access to controlled substances and protect our ability to prescribe for you. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. This agreement is valid indefinitely throughout your care with Riverside Pain Physicians.

The long-term use of controlled substances such as opioids, benzodiazepines, tranquilizers, and barbiturate sedatives is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when the use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness to treat your chronic pain.

I understand that all controlled substances must come from my pain physicians at Riverside Pain Physicians unless specific authorization is obtained for an exception. I understand that multiple prescribing sources are illegal in Florida. I will not obtain pain medications from any other physicians. Doing this will constitute a breach of this contract and will immediately end any and all responsibility on behalf of my physician for further care.

I will communicate fully and honestly with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. I am expected to inform the pain clinic of any new medications or medical conditions, and of any adverse effects that I experience from any of the medications that I take.

I understand that the risks associated with controlled medications include dependence, addiction, tolerance and constipation, sleep changes, potential for increased pain, risk to unborn children, withdrawal, and changes in appetite, coordination, sexual desire and sexual performance.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., while under the care of Riverside Pain Physicians. I understand that my urine and/or blood may be tested at any time for levels of controlled substances in my system. If any are discovered on random drug screens, I may not be able to get prescription refills of narcotics. I will not share, sell or trade my medication with anyone. I will not alter my prescriptions under any circumstance, and understand that you keep copies of all prescriptions. I agree to keep all medications out of the reach of others, including pets and children, as they may be hazardous or lethal to such individuals.

I agree to safeguard my pain medicine from damage, loss or theft and understand that damaged, lost or stolen medicines cannot be replaced. In the event of theft, I must file a police report for replacement of narcotics. I will not discard or destroy any medications. I will bring any unused medications to the clinic for proper disposal. I understand that refills of my prescriptions for pain medicine can be made only at the time of an office visit. Narcotics cannot be prescribed after hours / on weekends.

Even if I am on stable doses of controlled medication, I agree to schedule and keep regular appointments with my physician as part of my routine medical care. I understand that I am responsible for monitoring and scheduling ahead of time to ensure that my prescriptions will not run short on a weekend or holiday. I agree to meet all financial obligations associated with my treatment. I agree to bring medications in for a pill / patch count whenever requested.

I agree not to drive, use heavy machinery, or perform any potentially dangerous activities that require my full concentration following the initiation or any changes in my medications. I understand that I should not resume such activities until I have been on a stable dose without side effects.

I agree to take all scheduled medications exactly as prescribed and not to exceed the maximum daily dose on medications. If I overuse medications without your explicit permission, they will not be replaced early. I further agree to inform my physician of any emergency medical treatment during which I received pain medications.

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

I understand that if I break any portion of this Agreement, my doctor may stop prescribing these pain-control medicines and may not elect to discharge me from the clinic. In this case, my doctor may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I agree to use only the pharmacy listed below for filling prescriptions of all controlled substances. I will notify my pain physician prior to changing my pharmacy for any reason.

Pharmacy	
Address	
Phone	

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion to my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. Authorities may be given full access to my records held by Riverside Pain Physicians without order of clerk or court. I give my consent for the physicians and staff to speak with my pharmacist and other physicians to exchange pertinent information regarding any medical condition.

All of my questions and concerns regarding pain medication prescribing have been adequately answered. A copy of this document will be provided me upon request. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

Patient Sign:	Date:

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

Riverside Pain Physicians New Patient Database

PATIENT NAME

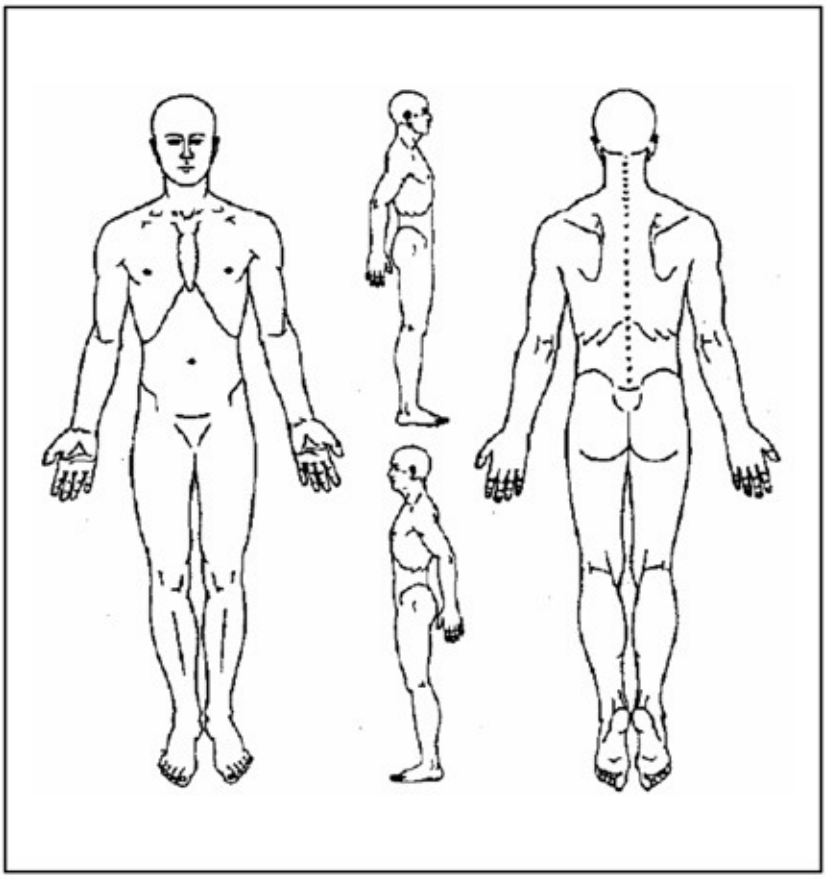
DATE OF BIRTH

REFERRING PHYSICIAN

IMPORTANT!! INSTRUCTIONS TO PATIENT:

Bring any relevant medical records, Xray and MRI or CT scan reports & images if you have them, a copy of your **current medication list with dosages and frequency**, as well as all of your **current medication bottles**, etc. Completing this pain inventory and following these suggestions will make your first visit with us smooth and productive.

Please color your areas of pain on the diagrams below. Be sure to show pain going down the arms or legs.



TELL US ABOUT YOUR MOST SIGNIFICANT AND DISTRESSING PAIN PROBLEM

WHERE is your MOST SIGNIFICANT AND DISTRESSING pain?

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

Was there an ACCIDENT OR INJURY? Give the DATE, and please describe.
WHEN did THIS PARTICULAR pain start?
Are you followed by a WORKER'S COMPENSATION CASE MANAGER?
What is your average pain score, where 0=NO pain, and 10=MOST SEVERE pain imaginable: 0 1 2 3 4 5 6 7 8 9 10
How do you describe the QUALITY of your pain? sharp shooting aching throbbing deep electrical spastic/tight piercing burning
Does your pain radiate (travel) anywhere? (Where?)
Is this pain CONSTANT or INTERMITTENT?
What activities or positions INCREASE this pain? walking, standing, sitting, exercise, work activities, motion of the head, other:
What activities or positions DECREASE this pain? rest, heat, ice, physical therapy, TENS, chiropractic, injections, medications, other:
Do you experience NEW problems with your BOWEL MOVEMENT or BLADDER FUNCTION?
Do you have NUMBNESS or WEAKNESS anywhere?
Have you had NECK (Cervical spine) or BACK (Lumbar spine, Thoracic spine) SURGERY? Please provide Surgeon, Dates and Type of operation:
What THERAPIES or INTERVENTIONS have you had for YOUR CURRENT PAIN problem? (circle) physical therapy, spine injections, chiropractor, anti-inflammatory medications, pain medications, bedrest, TENS unit, a previous pain management physician, or NONE

Have you had any XRAYS or OTHER STUDIES done for YOUR CURRENT PAIN PROBLEM? (circle)

XRAYS, MRI, CAT Scan, EMG (needle testing of muscles), Nerve conduction study, Discogram, Myelogram, Others:

MEDICAL, SURGICAL, FAMILY, MEDICATION AND SOCIAL HISTORY

PAST MEDICAL HISTORY: Please DESCRIBE your medical problems or LIST DIAGNOSES.

PAST SURGICAL HISTORY: Please LIST your major surgical procedures & dates.

FAMILY HISTORY: LIST SERIOUS problems your PARENTS, GRANDPARENTS or CHILDREN experienced.

CURRENT MEDICATIONS:

DRUG ALLERGIES: What happens if you take this drug (reaction)?

ARE YOU ALLERGIC TO: IODINE, BETADINE, CONTRAST DYE, LATEX, or NONE

MEDICATIONS THAT THIN YOUR BLOOD: Do you take any of the following OR SIMILAR?

coumadin, plavix, aspirin 325, Goody's powder, aggrenox, ticlid, pletal, trental, heparin, lovenox, or OTHER, or NONE

DO YOU SMOKE? NO, or _____ PACKS, Cigars, Pipes per day / week

DO YOU EVER USE ANY STREET DRUGS? NO, or marijuana, cocaine, other:_____

DO YOU DRINK ALCOHOL? NO, or _____ drinks per day / week / month
DO YOU HAVE A HISTORY OF HEAVY ALCOHOL USE OR ALCOHOLISM? NO or YES

DO YOU HAVE A HISTORY OF ANY DRUG ADDICTION? NO or YES

Do you work outside of the home? NO, or occupation_____

FOR FEMALES OF CHILDBEARING AGE ONLY, many pain medications, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance that you may be pregnant? If NO, why not?

Patient Name: _____

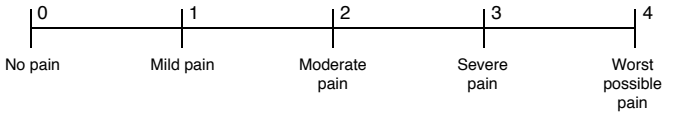
Date of Birth: _____

RIVERSIDE PAIN PHYSICIANS

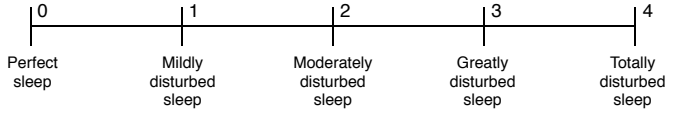
Functional Rating Index

In order to properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

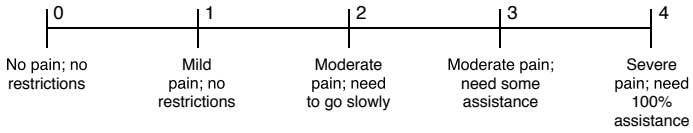
1. Pain Intensity



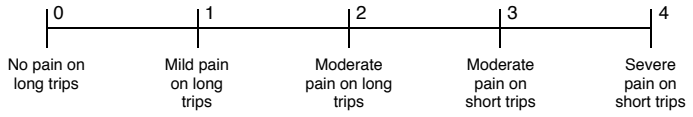
2. Sleeping



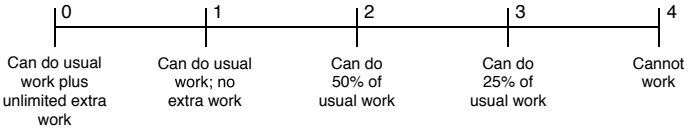
3. Personal Care (washing, dressing, etc.)



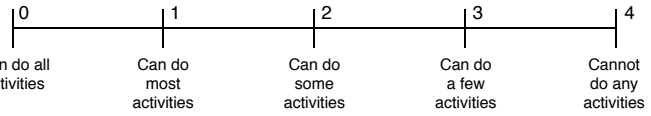
4. Travel (driving, etc.)



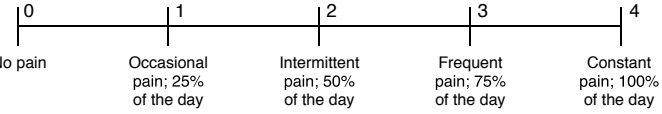
5. Work



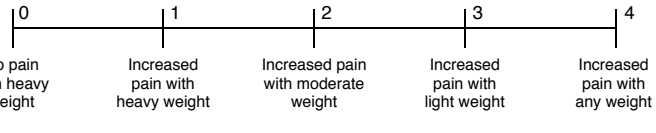
6. Recreation



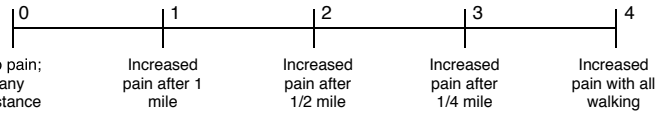
7. Frequency of Pain



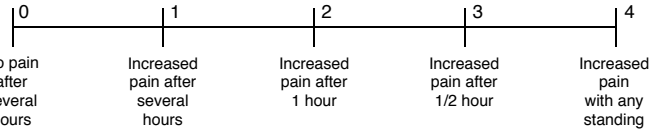
8. Lifting



9. Walking



10. Standing



Name _____ Total Score_____

PRINTED

_____ _____

PRINTED Date

Patient Name: _____

Date of Birth: _____

RIVERSIDE PAIN PHYSICIANS

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	O	O	O	O	O
2. How often have you felt a need for higher doses of medication to treat your pain?	O	O	O	O	O
3. How often have you felt impatient with your doctors?	O	O	O	O	O
4. How often have you felt that things are just too overwhelming that you can't handle them?	O	O	O	O	O
5. How often is there tension in the home?	O	O	O	O	O
6. How often have you counted pain pills to see how many are remaining?	O	O	O	O	O
7. How often have you been concerned that people will judge you for taking pain medication?	O	O	O	O	O
8. How often do you feel bored?	O	O	O	O	O
9. How often have you taken more pain medication than you were supposed to?	O	O	O	O	O
10. How often have you worried about being left alone?	O	O	O	O	O
11. How often have you felt a craving for medication?	O	O	O	O	O
12. How often have others expressed concern over your use of medication?	O	O	O	O	O

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

RIVERSIDE PAIN PHYSICIANS
RIVERSIDE SURGICAL CENTER

ACKNOWLEDGEMENT OF NOTICES

I acknowledge that I have received a copy of the following notices:

__X__ Patient's Bill of Rights and Responsibilities

__X__ Ownership Notice to Patients

__X__ Notice of Policy Regarding Advanced Directives

__X__ Privacy Practices / HIPAA

_____ _____

Patient's Signature Date

_____

Patient's Name Printed

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

RIVERSIDE SURGICAL CENTER, LLC

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

Advance Directives **are not honored** at this facility and in the event of an emergency or life-threatening situation, advance cardiac life support procedures **will be instituted** in every instance and patients will be transferred to a higher level of care.

Do you have an active Advance Directive? _____YES _____NO

Do you wish to provide a copy for your medical Record? _____YES _____NO

Patient Signature _____ Date _____

Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

OWNERSHIP NOTICE TO PATIENTS

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of 1992," FL Statute Section 455.654). Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have a right to obtain healthcare items or services at a location or from the provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

We have ownership interest in the following providers:

Surgery Partners
Riverside Surgical Center

Alternative facilities in which we do not have ownership:

St. Vincent's Hospital

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

Advance directives are not honored at this facility and in the event of an emergency or life-threatening situation, advanced cardiac life support procedures will be instituted in every instance and patients will be transferred to a higher level of care.

Patient Name: _____

Date of Birth: _____

RIVERSIDE PAIN PHYSICIANS

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of higher dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his/her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such research.
- Express complaints regarding any violation of his/her rights.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications including over-the-counter/Dietary Supplements, and any other information about his/her health.
- Reporting unexpected changes in his/her condition to the health care provider.
- Reporting to the health care provider whether he/she understands a planned course of action and what is expected of him/her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His/her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

FILING COMPLAINTS

- If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-2456 (Press 1) or write to the address below:

AGENCY FOR HEALTHCARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE, BUILDING 1
TALLAHASSEE, FLORIDA 32308

- If you have a complaint about a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

AGENCY FOR HEALTHCARE ADMINISTRATION
CONSUMER SERVICES UNIT
P.O. BOX 14000
TALLAHASSEE, FLORIDA 32317-4000

Agency for Health Care Administration
Visit us at www.FloridaHealthFinder.gov
Medicare Ombudsman, 1-800-MEDICARE

Patient's Initials _____

Patient Name: _____

Date of Birth: _____

RIVERSIDE PAIN PHYSICIANS

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer

RIVERSIDE PAIN PHYSICIANS

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C., 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Patient Name: _____ [redacted]

Date of Birth: _____

ty of your protected health information.

- We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applies to the following organizations:

Orange Park
7207 Golden Wings Rd, Ste 100
Jacksonville, Florida 32244

Monument
1205 Monument Road, Unit 301
Jacksonville, Florida 32225

Southside
7740 Point Meadows Drive, Suite 6
Jacksonville, Florida 32256

Jacksonville Beach
1375 Roberts Drive, Suite 205
Jacksonville, Florida 32250

RIVERSIDE
PAIN PHYSICIANS

PHARMACY MEDICAL RECORD RELEASE AUTHORIZATION

I authorize Riverside Pain Physicians to release my medical information, including, but not limited to, past medical history, treatment plan, diagnosis and prognosis to my pharmacy and/or pharmacist as required by my pharmacy and/or pharmacistto fill my prescription.

I understand that pharmacies and pharmacists must comply with the Health Insurance Portability and Accountability Act ("HIPAA") and maintain the privacy and security of my medical information.

Alcohol/drug/infectious disease/mental health records are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I understand that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law.

I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

I hereby grant such specific consent as evidenced by my signature below.

I may revoke this authorization at any time, in writing, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request.

I understand that this authorization will expire two years from the date of signature below.

I hereby release Riverside Pain Physicians from any and all legal liability that may arise from the release of this information to my pharmacy and/or pharmacistthe party named above.

_____ _____
PATIENT NAME DATE

_____
DOB

_____ _____
SIGNATURE OF PATIENT LEGAL REPRESENTATIVE
LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT