

DATE: \_\_\_\_\_



**AMERICAN MEDICAL INJURY  
CENTERS**  
YOUR HEALTH • OUR PRIORITY

First Name/Nombre:		M:	Last name /Apellido:		Patient Account Number:	
Street Address/Direccion:			City/Ciudad:		State/Estado:	Zip/Codigo Postal:
Home Phone/# Casa:		Work Phone/Trabajo:		Cell Phone/# Celular:		
Sex: Female Male	Marital Status: Single Divorced Married Other		Date of Birth/Fecha de Nacimiento:		Age/ Edad	
Patient Email:		Referred by: (Doctor)/Referido Medico:		(Attorney)/Abogado:		Spouse Name/Esposo/a:
IN CASE OF EMERGENCY - Contact:				Relationship:		
Home Phone:				Work Phone:		
<b>AUTOMOBILE ACCIDENT INFORMATION</b>						
Date of Accident/Fecha de Accidente:			Med Pay:Yes No		If yes, how much? \$	
Insurance Company:			Address:		City/State:	
Adjuster:		Claim #:			Phone #:	
<b>WORKERS' COMPENSATION INFORMATION</b>						
Date of Accident:		Employed By:			Phone #:	
Insurance Company:			Address:		City/State:	
Adjuster:		Claim #:			Phone #:	
Claim Rep:						
<b>OTHER ACCIDENT / INCIDENT INFORMATION</b>						
Other Accident/Incident Type (Describe Briefly):						
Insurance Company:			Address:		City/State:	
<b>ATTORNEY INFORMATION</b>						
Firm Name/Nombre de Firma:		Attorney Name/Abogado:			Phone #:	
Address:		City/State:			Zip:	

AccidentQuestionnaire / Personal Injury PATIENT INFORMATION AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of surgical and/or medical benefits to be paid directly to the physician, if any, otherwise payable to me for his/ her services as described realizing that I am responsible to pay for non-covered services. I further authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**INJURY DATE AND INFORMATION:**

Date of injury: \_\_\_\_\_

City/Town: \_\_\_\_\_

Intersection: \_\_\_\_\_

Route/Highway: \_\_\_\_\_

**YOUR POSITION IN AUTOMOBILE ACCIDENT:**

Were you  DRIVER  PASSENGER (FRONT or BACK)  OTHER: \_\_\_\_\_

**YOUR VEHICLE:**

Year, Make, Model,

\_\_\_\_\_

Your Estimated Speed at the moment of the accident: \_\_\_\_\_ MPH Stopped, Slowing down, Accelerating

Point of Impact to your Vehicle?  Light  Moderate  Heavy Damage Estimate \$ \_\_\_\_\_

AutoMobile accident description:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did the accident happen while you were on the job?  YES  NO

Name person driving the vehicle. (if not the patient) \_\_\_\_\_

**OTHER VEHICLE::**

Year, Make, Model \_\_\_\_\_

Estimated speed at the moment of accident? \_\_\_\_\_ MPH  Slowing  Stopped  Accelerating

Were there other vehicles involved?  Yes  No

If yes please describe below

\_\_\_\_\_  
\_\_\_\_\_

**SEATBELTS AND AIRBAGS**

Were you wearing a seat belt?  Yes  No Did Airbags Deploy?  Yes  No Did your seat Break/bend?  Yes  No

PATIENTS NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**AT THE TIME OF IMPACT**

Which way was your body pointed at the time of impact? \_\_\_Straight \_\_\_Right \_\_\_Left

Which way was your head pointed at the time of impact? \_\_\_Straight \_\_\_Right \_\_\_Left

Were you leaning forward at the time of impact? \_\_\_Yes \_\_\_No

Did you brace before impact or were you relaxed? \_\_\_Relaxed \_\_\_Braced

Against What? \_\_\_\_\_

Did any body part of yours strike anything within the vehicle at the time of impact? c Yes cNo

If "YES", specify what part of your body struck what: (i.e. head, chest, left shoulder, right knee, etc.)

\_\_\_\_\_ Steering wheel \_\_\_\_\_ Windshield \_\_\_\_\_ Dashboard

\_\_\_\_\_ Left side door \_\_\_\_\_ Right side door \_\_\_\_\_ Roof

\_\_\_\_\_ Left Window \_\_\_\_\_ Right Window \_\_\_\_\_ Other

Immediately after the accident, how did you feel? (Circle all that apply) Dizzy Dazed Upset Disoriented Nervous Nauseous  
Other \_\_\_\_\_

Did you lose consciousness? \_\_\_Yes \_\_\_No If so how long? \_\_\_\_\_

Were you able to get out of the vehicle on your own? \_\_\_Yes \_\_\_No

**TREATMENT AT THE SCENE OF ACCIDENT**

Did an ambulance come to the scene of the accident? \_\_\_Yes \_\_\_No

If yes, did you receive treatment at the scene of the accident? \_\_\_Yes \_\_\_No

What kind of treatment?  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT AT THE HOSPITAL**

Were you transported to the hospital? \_\_\_Yes \_\_\_No If yes, Which hospital? \_\_\_\_\_

How did you get there? \_\_\_Ambulance \_\_\_Private transportation \_\_\_Police \_\_\_Other

Were you admitted? \_\_\_Yes \_\_\_No If yes, How long? \_\_\_\_\_

What treatment was given at the hospital? (Check all that apply)

\_\_\_ X RAYS \_\_\_ MRI \_\_\_ CT \_\_\_ PAIN MEDICATIONS \_\_\_STICHES \_\_\_MUSCLE RELAXANTS \_\_\_ BANDAGES \_\_\_CERVICAL

\_\_\_PHYSICAL THERAPY \_\_\_INSTRUCTED REGARDING CONCUSSION \_\_\_ INSTRUCTED REGARDING SPRAINS/STRAINS

\_\_\_ INSTRUCTED TO CALL ORTHOPEDICS \_\_\_ INSTRUCTED TO CALL PRIMARY CARE DOCTOR \_\_\_ OTHER

**OTHER DOCTORS**

Have you seen any other doctors prior to coming to see us?  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name \_\_\_\_\_

Date: \_\_\_\_\_

List all medications that you were taking before the accident.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? YES NO

If yes, which medication(s)? \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_\_ with whom? \_\_\_\_\_

**LIST OF MAJOR SURGERIES**

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Have you had any major falls or accidents (automobile) in the past 3 years? Please describe below:

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL AND OCCUPATIONAL HISTORY :** Employed by: \_\_\_\_\_ Unemployed Student

Type of work: \_\_\_\_\_

# of children and ages: \_\_\_\_\_

(1.) Do you smoke cigarettes/tobacco? Yes No      (2.) Do you use any illegal substances? Yes No

(3.) Do you consume alcohol? Yes No Occasional      (4.) Are you HIV+/AIDS? Yes No

**FEMALES ONLY**

Date of last menstrual cycle \_\_\_\_\_

Is there a possibility you may be pregnant? Yes No

If yes, due date \_\_\_\_\_

Currently taking birth control pills? Yes No

Currently taking Hormone replacements? Yes No

**PREVIOUS ILLNESSES**

Please advise which of the following conditions you have ever had.

ASTHMA:	SEIZURES:	NERVOUS CONDITIONS:
Arthritis/Back pain	HEART PROBLEMS:	MENTAL ILLNESSES:
DEPRESSION:	DIABETES:	CANCER:
HIGH BLOOD PRESSURE:	STROKE:	HEADACHES:

**FAMILY HISTORY :**

Has your mother or father had any of these above conditions?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

PATIENTS NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## The Rivermead Post-Concussion Symptoms Questionnaire\*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0= Not experienced at all 1=No more of a problem 2=A mild problem  
3=A moderate problem 4=A severe problem

Headaches.....	0	1	2	3	4
Feelings of Dizziness.....	0	1	2	3	4
Nausea and /orVomiting.....	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise.....	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily.....	0	1	2	3	4
Being Irritable, easily angered.....	0	1	2	3	4
Feeling Depressed or Tearful.....	0	1	2	3	4
Feeling Frustrated or Impatient.....	0	1	2	3	4
Forgetfulness, poor memory.....	0	1	2	3	4
Poor Concentration.....	0	1	2	3	4
Taking Longer to Think.....	0	1	2	3	4
Blurred Vision.....	0	1	2	3	4
Light Sensitivity, easily upset by bright light.....	0	1	2	3	4
Double Vision.....	0	1	2	3	4

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### CHIEF COMPLAINTS

*Please "X" any complaints that you have been experiencing since your accident (FIRST 2 columns).*

**PATIENT PLEASE CHECK OFF/CIRCLE COMPLAINTS**

**FOR DOCTOR USE ONLY**

COMPLAINTS LOCATION							DESCRIPTION / REMARKS
NECK PAIN	LT	RT	MID	BILAT			
JAW PAIN	LT	RT	MID	BILAT			
UPPER BACK PAIN	LT	RT	MID	BILAT			
MID BACK PAIN	LT	RT	MID	BILAT			
SHOULDER PAIN	LT	RT	BILAT				
ARM / WRIST PAIN	LT	RT	BILAT				
HAND / FINGER PAIN	LT	RT	BILAT				
LOW BACK PAIN	LT	RT	BILAT				
HIP PAIN	LT	RT	BILAT				
LEG / KNEE PAIN	LT	RT	BILAT				
ANKLE / FOOT / TOES	LT	RT	BILAT				
NUMBNESS AND TINGLING	LT	RT	BILAT				
RADIATING PAIN	LT	RT	BILAT				
HEADACHES	LT	RT	FRONT	OCC			Duration: Freq:

PATIENT NAME : \_\_\_\_\_ DATE: \_\_\_\_\_

**OTHER COMPLAINTS**

**Please "X" any complaints that you have been experiencing since your accident (left column).**

FOR DOCTOR USE ONLY

	Anxiety Doctors Notes
	When I am traveling in a vehicle
	When someone else is driving and I do not feel in control
	When another vehicle is following too close to me
	When I get near the scene of where the accident occurred
	Other:
	Difficulty Sleeping
	Because of pain and discomfort
	Nightmares about the accident
	Other:
	Please indicate the number of hours you are able to sleep at night:
	Depression
	What do you feel is causing you to be depressed?
	Memory Loss
	Concentration
	Other

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**DUTIES UNDER DISTRESS**

Are there day to day activities which are painful or difficult for you to perform as a result of your injuries? Check all those that apply & write in the reason why you have difficulty performing the activity

		Reason for the difficulty	Duration
	Work		
	Studies/ school		
	<b>Domestic duties</b>		
	Vacuuming		
	Taking care of children		
	Dishes/Dusting/Laundry		
	Preparing Meals		
	Personal care/Bathing/dressing		
	Other		
	<b>Household Duties</b>		
	Mowing/Yard work		
	Transporting Family		
	Shopping		
	Taking Trash Out		
	Other		

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**LOSS OF ENJOYMENT**

Are there areas of your life which you normally would be enjoying but are currently not enjoying, as a result of your injuries?

	Hobbies/Recreation	Reason for the difficulty	Duration
	Jogging		
	Dancing		
	Shopping		
	Traveling		
	Working out		
	Other		
	Other		
	Sports		
	Social		
	Competitive		
	Other		
	Sexual Relations		
	Other		

# Authorizations and Releases / Financial Policy

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## CONSENT FOR TREATMENT OF MINOR

\_\_\_\_\_ I hereby authorize the Doctors of AMERICAN MEDICAL INJURY CENTERS, and whomever they may designate as their assistant(s), to perform diagnostic Initial tests, and to administer treatment as he/she deems necessary to my child, (Child's name) \_\_\_\_\_ of which I am the legal guardian.

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

\_\_\_\_\_ I authorize the release of any of my medical information and protected health information to the extent necessary to process my insurance claim(s) and for all other payments, treatment and healthcare operations required of AMERICAN MEDICAL INJURY CENTERS related to the services provided to me. I also certify all insurance information given by me to AMERICAN MEDICAL INJURY CENTERS is correct and complete

## REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

\_\_\_\_\_ I hereby authorize my Insurance Company/Insurance Administrator to pay unto AMERICAN MEDICAL INJURY CENTERS for any Initial benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges out of the proceeds of my settlement and understand that my attorney will be billed for said balance. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my outstanding medical bill only.

## ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

\_\_\_\_\_ I, the undersigned patient am directing my Attorney, \_\_\_\_\_, to pay Initial any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment as services are rendered.

## PAYMENT POLICY

### Health Insurance:

Proof of Insurance must be provided in order for us to file claims with your insurance company. Please understand that benefits through health insurance policies differ. Insurance companies pay according to your individual policy limits. Benefits are between you and your insurance company. You with your insurance company MUST handle any discrepancy regarding benefit coverage. Any portion of your bill that is not paid by your health insurance will be billed to your Attorney and will be paid at the time of your settlement.

### Auto Insurance:

We cannot file against the adverse driver's insurance in an automobile accident. If Med Pay is available, we can and will file against either your automobile insurance, or the owner of the vehicle you were a passenger in. If medical benefits are available there may be a maximum allowable amount of coverage which may not cover all charges in full. In that event you will be responsible for the remaining balance and your Attorney will be billed.

### Worker's Compensation:

We will file claims with your employer's workers' compensation insurance company upon approval of each visit or procedure by the proper authority in the case. Should the case be controversial or denied for any reason we cannot file with the workers' compensation insurance on future claims and you will be responsible for the unpaid claims unless financial arrangements with your attorney have been made.

**PATIENT REFUND POLICY** -The Doctors of AMERICAN MEDICAL INJURY CENTERS expect to be paid by the first available means whether by health insurance, med pay or settlement of your case. Should an overpayment be made and you have a credit balance on your account a refund will be issued to either you or the appropriate party.

## I UNDERSTAND, AGREE TO AND WILL ABIDE BY ALL OF THE ABOVE.

Patient Name or Responsible Party: \_\_\_\_\_

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

**Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete:** If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, call and speak to a supervisor.

**Right to Get a List of Certain Disclosures of Your Medical Information:** You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, call a Supervisor. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

**Right to Request Restrictions on how the Clinic Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations:** You have the right to request that the Clinic not make disclosures of your medical information to treat you, to seek payment for care, or to operate the Clinic. In many cases, the Clinic is not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Supervisor and describe your request in detail. However, the Clinic must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want the Clinic to disclose medical information to your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment.

**Right to Request Confidential Communications:** You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Supervisor. Upon request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

**Duties of the Clinic:** The Clinic is required by law to protect the privacy of your medical information, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. The Clinic is also required to notify you if there is a breach of your unsecured medical information.

**Which Health Care Providers are Covered:** This Notice of Privacy Practices applies to the Clinic and its personnel, volunteers, students and trainees. This Notice also applies to other health care providers when they come to the Clinic to care for patients, such as physicians, physician assistants, therapists, other health care providers who are not employed by the Clinic. However, these other health care providers may follow different practices at their own offices or facilities.

**Changes to this notice:** From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by contacting the Clinic.

**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.**

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the Clinic and how we may disclose it to others outside the Clinic. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

**How will we use and disclose your medical information? Treatment:** We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, and others involved in your care.

For example, we will allow your primary care physician to have access to your Clinic medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

**Family Members, Legal Counsel, and Others Involved in Your Care:** We may disclose your medical information to a family member, legal counsel, or friend who is involved in your medical care, or to someone who helps to pay for your care.

**Payment:** We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan, Health Insurance Company, or attorney may ask to see parts of your medical record before they will pay us for your treatment.

**Clinic Operations:** We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Clinic. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by clinic personnel, your doctors, or other health care professionals.

**Required by Law:** Federal, state, and local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

**Public Health:** We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

**Public Safety:** We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct at the Clinic. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

**Military, Veterans, National Security and Other Government Purposes:** If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The Clinic may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

**Judicial Proceedings:** The Clinic may disclose medical information if the Clinic is ordered to do so by a court or if the Clinic receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

**Information with Additional Protection:** Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, the Clinic is required to get your permission before disclosing that information to others in many circumstances.

**When is Your Authorization Required? Uses and Disclosures for Which Your Authorization is Required:** With limited exceptions, the Clinic must obtain your written authorization before it may disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

**Other Uses and Disclosures Requiring Authorization:** If the Clinic wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the Clinic will seek your written authorization. If you give your authorization to the Clinic, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify the Supervisor in writing.

## NOTICE OF PRIVACY PRACTICE PATIENT ACKNOWLEDGEMENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I HAVE RECEIVED THIS PRACTICE'S Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of uses and disclosures that are prohibited or material limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the secretary of HHS if i believe my privacy right have been violated, and that no retaliatory action will be used against me in the event of such a complaint
  - The right to request restrictions on certain uses and disclosure to protect my health information and that this practice does not require me to agree to a requested restriction.
  - The right to receive confidential communication of protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the notice of privacy from this practice upon request.

The practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if signed by a personal representative of Patient): \_\_\_\_\_

ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES

ATTORNEY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT: \_\_\_\_\_  
D/A: \_\_\_\_\_ DOB: \_\_\_\_\_  
SNN: \_\_\_\_\_

FOR VALUE RECEIVED, I hereby assign unto American Medical injury Centers and/or its physicians hereinafter referred to American Medical injury Centers, to the extent of my bill for health care services and all claims which i may against any other party whose NEGLIGENCE may have caused my injuries on the above caption date or who may be legally responsible for my injuries and health costs.I further assign to American Medical Injury Centers, an irrevocable lien in the amount of my outstanding medical bill for health care services rendered for an accident which occurred on the above captioned date against the proceeds of any insurance policy, health care plan, or any claim which I may have against any other party whose negligence may have caused my injuries. I fully understand & agree not to rescind my directive to my attorney to honor this lien. I hereby authorize payment be made directly to the AMERICAN MEDICAL INJURY CENTERS or its Assignee. I hereby appoint American Medical Injury Centers as my irrevocable attorney in fact, to ask, demand, sue for, collect, endorse, sign, and receive any such insurance or other benefits or claims against other parties for my injuries. Although American Medical Injury Centers shall be granted such powers contained herein, AMERICAN MEDICAL INJURY CENTERS are not obligated or compelled to exercise such powers but may do so at American Medical injury Centers discretion. American Medical Injury Centers are further empowered to provide any and all information and documents pertaining to my policies of insurance, including a copy of such policy and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim. I fully understand & agree not to rescind my directive to my attorney to honor this lien. Failure of my Attorney to sign this document does not re- lease him/her of the fiduciary responsibility of ensuring that my outstanding medical bill is paid unto American Medical Injury Centers. BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENTED TO REGIONAL MEDICAL GROUP AND ITS DOCTORS FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION OCCURRING ON THE ABOVE DATE AND FOR NO OTHER PURPOSE

BY SIGNING THIS DOCUMENT, PATIENT FULLY UNDERSTANDS ALL PROVISIONS SET FORTH IN THIS AGREEMENT. A PHOTOCOPY OR FAX COPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain enforceable. This agreement is governed by Georgia law. I expressly direct my attorney (below) to hold in the Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay American Medical Injury Centers for services rendered on Patient's behalf by American Medical Injury Centers.

IN WITNESS WHEREOF, the Agreement has been entered the day and year set forth below.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESSES

\_\_\_\_\_  
DATE

**TO BE COMPLETED BY ATTORNEY:** The undersigned Attorney of Record for the above-named Patient, hereby agrees to observe all terms stated herein and agrees to withhold such sums "payable" or "due and owing to" American Medical Injury Centers " from any settlement, judgment or verdict as may be necessary to adequately protect American Medical Injury Centers. The Attorney is expressly directed to hold in Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay American Medical Injury Centers for services rendered on Patients behalf by AMERICAN MEDICAL INJURY CENTERS. The Attorney is further directed to pay from the Attorney's Client Trust Account to American Medical Injury Centers that amount which is due and owing to American Medical Injury Centers for those medical services, examinations, treatments and reports which American Medical Injury Centers have performed on the Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of this Agreement, and secure new counsel's consent there to. Failure of Attorney to sign and return this document to American Medical Injury Centers does not release him/her of the fiduciary responsibility of ensuring that the above Patient's outstanding medical bill for treatment rendered for injuries sustained on the above captioned date is paid unto American Medical Injury Centers out of the proceeds of his/her case per your client's written request.

\_\_\_\_\_  
ATTORNEY SIGNATURE

\_\_\_\_\_  
DATE

Attorney: Please sign and mail or fax to AMERICAN MEDICAL CENTER at the address/fax # below



**AMERICAN MEDICAL INJURY  
CENTERS**

YOUR HEALTH • OUR PRIORITY

**RELEASE OF X-RAYS AND MEDICAL RECORDS**

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

I, \_\_\_\_\_, request the release of my x-rays and or  
medical records from \_\_\_\_\_.

I release \_\_\_\_\_ from any and all  
claims resulting from the release as i realized they are part of your permanent records.

SIGNATURE : \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_

## Pharmacy Information:

Name of pharmacy: \_\_\_\_\_

Phone number of pharmacy:

\_\_\_\_\_

Address of Pharmacy:

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_