ELITE RHEUMATOLOGY
AND ARTHRITIS CENTER
WE LISTEN. WE DIAGNOSE. WE HEAL.

Sunshine Specialty Health Care

1727 Orlando Central Pkwy, Orlando, FL 32809.
Ph:(407)888-5980, Fax: (407)888-2492
Elite Rheumatology and Arthritis Center operates under the legal business name Sunshine Specialty Healthcare LLC

Name: _____ **Date of Birth:** _____

Phone Number (Mobile): _____ **Email:**

SMS/Email/Phone Call Consent and Communication Agreement

By signing below, I consent to receive SMS messages/Emails/Phone calls from **Sunshine Specialty Healthcare LLC / Elite Rheumatology and Arthritis Center** (the "Clinic") for the purpose of appointment reminders, order alerts, account notifications, and other healthcare-related communications. I understand that these messages may be sent to the mobile phone number I have provided, and may include important information related to my care.

Message Frequency and Date Rates :

- The frequency of messages will vary based on my appointment schedule, account activity, and other healthcare-related updates.I understand that standard message and data rates may apply based on my mobile carrier's plan. I am responsible for any charges incurred for receiving SMS messages/emails/phone calls/voicemails.

Opting Out and Help Request:

- I understand that I may opt out of receiving SMS notifications at any time by texting "STOP" to the number from which the messages are sent.
- If I need assistance or have questions regarding SMS messages, I can text "HELP" to the number from which the messages are sent for more information or support.

Privacy and Data Protection:

- I acknowledge that my personal information, including my mobile phone number, will be handled in accordance with the Clinic's Privacy Policy. SMS opt-in and phone numbers collected for SMS communication purposes will not be shared with any third party and affiliates for marketing purposes.My phone number and other personal information will not be shared or sold to third parties, except as required by law.

By signing below, I consent to receive SMS notifications as described above and confirm that I understand and agree to the terms outlined in this SMS Consent Form.

Patient Signature: _____**Date:** _____