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

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Sunshine Specialty Health Care, and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Sunshine Specialty Health Care.

I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Sunshine Specialty Health Care Notice of Privacy Practices.

I authorize payment of medical benefits to Sunshine Specialty Health Care, physicians or their designee for services rendered. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice.

PATIENT SIGNATURE: _____