ELITE RHEUMATOLOGY AND ARTHRITIS CENTER

WE LISTEN. WE DIAGNOSE. WE HEAL.

CANCELLATION POLICY

WE RESPECTFULLY REQUEST AT LEAST 24-HOUR NOTICE FOR CANCELLATIONS OR RESCHEDULING OF APPOINTMENTS.

PATIENT WHO FAILS TO CANCEL THEIR APPOINTMENT OR NO SHOW TO THEIR APPT. WILL BE CHARGED A $25.00 FEE.

I HAVE READ AND UNDERSTAND THE SUNSHINE SPECIALTY HEALTH CARE APPOINTMENT CANCELLATION / NO SHOW POLICY AND AGREE TO ITS TERMS.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN: _____

DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILTY & ACCOUNTBILITY ACT OF 1996 (HIPPA). I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN ANF DIRECT MY TREATMENT AND FOLLOW- UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN MY TREAMENT DIRECTLY AND/OR INDIRECTLY.
2. OBTAIN PAYMENT FROM THIRD PARTY PAYERS
3. CONDUCT NORMAL HEALTHCARE OPERATION SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOCTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FORM, FROM TIME TO TIME AND THAT I MAY CONTACT THE ORGANIZATION AT ANY TIME OR GO TO THE COMPANYIS WEBSITE TO OBTAIN A CURRECT COPY OF THE NOTICE OF PRIVACY

PATIENT SIGNATURE: _____

DATE: _____