



**NEW PATIENT DEMOGRAPHICS**

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

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ CELL PHONE NUMBER: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

LAST FOUR OF S.S.: \_\_\_\_\_ GENDER AT BIRTH: \_\_\_\_\_

RACE: \_\_\_\_\_ LANGUAGE: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

EMERGENCY CONTACT TEL: \_\_\_\_\_ RELATION: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

NAME OF PHARMACY PREFERRED: \_\_\_\_\_

PHARMACY PHONE NUMBER: \_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_

**\*\*\* WE MAY ALSO PLACE ROSEMONT SPECIALTY PHARMACY ON FILE FOR YOU AS IT IS THE PHARMACY  
USED FOR SPECIALTY MEDICATION AND BIOLOGICS \*\*\***

PREVIOUS/CURRENT PRIMARY PHYSICIAN NAME: \_\_\_\_\_

PRIMARY CARE PHONE NUMBER: \_\_\_\_\_

PRIMARY CARE FAX NUMBER \_\_\_\_\_

PREFERRED LABORATORY FOR BLOOD DRAW: \_\_\_\_\_

PRIMARY INSURANCE NAME: \_\_\_\_\_

PRIMARY INSURANCE ID #: \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_

SECONDARY INSURANCE ID #: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## General Consent for Treatment & Financial Authorization

- **Consent to Treatment:** I hereby voluntarily consent to and authorize Sunshine Specialty Healthcare LLC, its physicians, clinicians, and authorized personnel to provide medical care, treatment, diagnostic procedures, and other health care services deemed medically necessary in their professional judgment. I acknowledge that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me regarding the results of any treatment, procedure, or examination.
- **Acknowledgment of Risks:** I understand that all medical treatments and procedures involve potential risks, benefits, and alternatives, which may be explained to me as appropriate. I have had the opportunity to ask questions and have them answered to my satisfaction.
- **Use and Disclosure of Health Information (HIPAA):** I authorize Sunshine Specialty Healthcare LLC to use and disclose my (or the patient's) protected health information (PHI) for purposes of treatment, payment, and health care operations, in accordance with applicable federal and state laws and the clinic's Notice of Privacy Practices.
- **Assignment of Benefits & Financial Responsibility:** I hereby assign and authorize direct payment of all medical benefits to Sunshine Specialty Healthcare LLC, its physicians, or their designated billing entity for services rendered. I understand that I am financially responsible for any charges not covered by insurance, including but not limited to copayments, deductibles, coinsurance, and non-covered services.
- **Prescription History & E-Prescribing Authorization:** I authorize the practice to access my medication and prescription history through electronic prescribing systems, including pharmacy benefit managers and other third-party databases, for the purpose of ensuring safe and effective medical treatment.
- **Notice of Privacy Practices:** I acknowledge that I have received, reviewed, or been offered a copy of the Sunshine Specialty Healthcare LLC Notice of Privacy Practices.

## Patient Acknowledgment

I have read and understand the above policies. I agree to comply with the clinic's procedures and communication standards. I understand that I may request a copy of this form and ask questions at any time.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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



**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly and/or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice 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 from time to time and that I may contact the organization at any time or visit the company’s website to obtain a current copy of the Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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



## **HIPAA Compliance Patient Consent**

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You acknowledge that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatment, payment or healthcare operations:

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- Sunshine Specialty Health Care reserves the right to change the privacy policy by law.
- Sunshine Specialty Health Care has the right to restrict the use of the information but does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- Sunshine Specialty Health Care may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? \_\_\_\_\_

May we leave a voicemail? \_\_\_\_\_

Please list who we may discuss medical information with:

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

DOB : \_\_\_\_\_

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

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



**SUNSHINE SPECIALTY  
HEALTH CARE**

*Where your health is our priority!*



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

1727 Orlando Central Parkway \* Orlando, Fl. \* 32809 \* Phone 407-888-5980 \* Fax 407-888-2492

### **CANCELLATION POLICY**

We respectfully request at least 48 hours' notice for any appointment cancellations or rescheduling. Frequent cancellations or rescheduling of appointments may result in termination of care at our facility.

Patients who fail to cancel their appointment or do not show up for their scheduled visit 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.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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



### Patient Consent for Communication via Phone, Text, and Email

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

Date of Birth: \_\_\_\_\_

Preferred Language:  English  Español

#### Phone Communication

I consent to receive phone calls from Sunshine Specialty Healthcare regarding appointments, care instructions, and clinic updates.

Yes, I approve of phone calls to:  
Phone Number: (\_\_\_\_) -

No, I do not approve of phone communication.

#### Text Messaging

I consent to receive text messages for appointment reminders, health tips, and clinic updates. Standard messaging rates may apply.

Yes, I approve text messages to:  
Mobile Number: (\_\_\_\_) -

No, I do not approve text communication.

#### Email Communication

I consent to receiving emails regarding appointment reminders, patient education, and clinic news.

Yes, I approve emails to:

Email Address: \_\_\_\_\_

No, I do not approve email communication.

#### Patient Acknowledgment

**I understand that while Sunshine Specialty Healthcare takes precautions to protect my information, electronic communications may carry various privacy risks. I may revoke this consent at any time in writing.**

Patient Signature: \_\_\_\_\_

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



**Patient Consent for Telephone, Email, and Portal Communication Billing**

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

Date of Birth: \_\_\_\_\_

**Purpose:**

I understand and consent that Sunshine Specialty Healthcare LLC and its providers may bill for telephone calls, emails, or patient portal messages that involve medical decision-making or clinical management of my care, when appropriate and in accordance with applicable regulations.

**What is Covered:**

- Telephone, email, or portal communications that require your provider to review your chart, interpret results, make medical decisions, or provide medical advice.

**What is Not Covered:**

We will not bill for the following:

- Prescription refills • Appointment scheduling or rescheduling • Requests for test results or reports without additional medical decision-making.

**Billing Information:**

These services will be billed to your insurance just like an office or telehealth visit. You may be responsible for any applicable co-pay, deductible, or co-insurance as determined by your insurance plan.

**Patient Acknowledgment:**

By signing below, I acknowledge that I have read and understood the above information. I consent to Sunshine Specialty Healthcare LLC and my provider billing for telephone, email, or portal encounters that involve medical decision-making. I understand that I may be responsible for any portion not covered by my insurance.

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

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



**Clinic Policies Acknowledgment:** Please review the following clinic policies carefully:

- **Late Arrivals:** Patients arriving more than 5 minutes late to their appointment may be canceled or rescheduled at the clinic’s discretion.
- **Telehealth Visits:** Telehealth appointments are available only with provider approval.
- **Cancellations:** Appointments must be canceled at least 48 hours in advance to avoid a no-show fee. Repeated no-shows or late cancellations may result in dismissal from the clinic.
- **Forms & Documentation:** Consent forms must be signed to send or obtain medical records. All new patient paperwork must be completed and returned prior to the visit. Otherwise, patients must arrive 30 minutes early and bring all necessary records.
- **Insurance Responsibility:** Patients are responsible for understanding their insurance benefits and providing up-to-date insurance information prior to the visit.
- **Referrals & Payments:** Patients are responsible for obtaining required referrals and understanding their copay, deductible, and coinsurance. Payment is expected at check-in.
- **Payment Policy:** Copays, deductibles, coinsurance, and outstanding balances are due at the time of service. Payment plans may be available.
- **Conduct Policy:** Disrespectful behavior toward staff will not be tolerated and may result in dismissal from the clinic.
- **Medication Refills:** Patients should first contact their pharmacy to confirm refill availability. If no refills are available, the pharmacy should send a request to the clinic. Please allow up to 72 hours for processing. A follow-up visit may be required if the patient has not been seen recently.
- **Students/Externs:** Patients consent to the presence of supervised students or externs during their visit.
- **Check-Out Requirement:** Patients must check out at the front desk after their visit to receive orders, forms, and follow-up instructions.

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**Patient Acknowledgment:** I have read and understand the above policies. I agree to comply with the clinic’s procedures and communication standards. I understand that I may request a copy of this form and ask questions at any time.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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



### Authorization for Release of Medical Records

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

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

FROM:

TO:

Name: \_\_\_\_\_

Name/Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I hereby authorize the release of my protected health information as indicated below:**

- Complete Medical Record  Office Visit Notes  Laboratory Results
- Imaging Reports  Medication List / Prescriptions  Immunization Records
- Billing Records  Other (specify): \_\_\_\_\_

#### Purpose of Disclosure

- Continuity of Care  Personal Use  Insurance  Legal
- Other: \_\_\_\_\_

I understand that my records may include information related to:

- Mental health
- Substance use
- HIV/AIDS
- Genetic testing
- Sexual health

- I authorize release of ALL sensitive information
- I DO NOT authorize release of sensitive information

**I understand that once my records are released, they may no longer be protected under HIPAA. I authorize the release of my medical information as indicated above.**

Patient/Legal Representative Name: \_\_\_\_\_

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

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