SUNSHINE SPECIALITY 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

NEW PATIENT DEMOGRAPHICS FORM

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 #: _____ RELATIONSHIP: _____

EMERGENCY CONTACT NAME: _____

NAME OF PHARMACY PREFERED: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

PREVIOUS/CURRENT PRIMARY PHYSICIAN NAME: _____

PRIMARY CARE PHONE NUMBER: _____

PREFERED LABORATORY FOR BLOOD DRAW: _____

PRIMARY INSURANCE NAME: _____

PRIMARY INSURANCE ID #: _____

SECONDARY INSURANCE NAME: _____

SECONDARY INSURANCE ID #: _____

PATIENT SIGNATURE: _____ DATE: _____

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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 : _____

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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:

PATIENT SIGNATURE : _____

DATE : _____

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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: _____

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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: _____

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MEDICAL RECORDS REQUEST

I HEREBY REQUEST AND AUTHORIZE RELEASE COPIES OF MY MEDICAL RECORDS TO:

SUNSHINE SPECIALTY HEALTH CARE LLC. (SSHC)
ELITE RHEUMATOLOGY AND ARTHRITIST CENTER

RECORDS CAN BE SENT VIA MAIL VIA P2P SOFTWARE EXCHNGE OR REGULAR OFFICE TO OFFICE FAX.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN COPIES OF THE INFORMATION RECIVIED FROM ANOTHER HEALTH CARE FACILITY OR DOCTOR.

I ALSO AUTHORIZE RELEASE OF THE FOLLOWING TO SUNSHINE SPECIALTY HEALTH CARE LLC. (SSHC

TYPE OF INFORMATION TO BE DISCLOSED:

ENTIRE MEDICAL RECORD	RADIOLOGY REPORTS	ALL HOSPITAL RECORDS
SPECIALIST CONSULTATION NOTES	BILLING STATEMENTS	DISCHARGE SUMMARY
DENTAL RECORDS	PATHOLOGY REPORTS	LABORATORY REPORTS
OFFICE CHART NOTES	EMERGENCY DEPARTMENT REPORTS	LAST 3 VISIT PROGGRESS NOTES

PATIENT SIGNATURE: _____ DATE: _____

LAST 4 DIGITS OF SS #: _____

EXPIRATION DATE OF AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS IS ONE YEAR FROM PATIENT SIGNATURE.

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Fax Cover Sheet

FROM: SUNSHINE SPECILATY HAELTHCARE
1727 ORLANDO CENTRAL PARKWAY
ORLANDO, FLORIDA
TEL: 407-888-5980 FAX: 407-888-2492

Confidential health information is faxed to you after appropriate consents have been obtained. You, as the recipient, are obligated to maintain it in a safe and confidential manner. Re-disclosure without additional patient consent is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to federal and state law penalties.

TO: _____

_____

_____

NUMBER OF PAGES: _____ DATE: _____

REGARDING: _____

_____

_____

Confidentiality Notes

This facsimile transmission may contain confidential or legally privileged information which is intended only for the use of the individual or entity named on this transmittal sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying distribution, or reliance upon the contents of the facsimile is strictly prohibited. If you have received this facsimile transmission in error, please notify us immediately by telephone so that we can arrange for the return of the transmitted materials to us at no cost to you.

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Patient Consent for Telephone, Email, and Portal Communication Billing

Purpose:

This consent form allows Sunshine Specialty Healthcare LLC and its providers to bill for telephone calls, emails, or patient portal messages that involve medical decision-making or clinical management of your care.

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: _____

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Clinic Policies Acknowledgment Form

- Patients later than 15 minutes to their appointment can be cancelled or rescheduled at clinics discretion.
- Repeated no-shows may result in being discharged from clinic.
- Tele health is available at providers' discretion.
- If clinic is not notified a no-show fee can be incurred.
- Consent form must be signed to send or obtain records.
- It is your responsibility to know your benefits, have your referral and records at the time of your visit.
- Copays and balances are due at the time of service.
- I will treat staff and other patients with courtesy and respect.
- Disruptive behavior may result in dismissal from the clinic.
- I am responsible for providing accurate insurance information.
- I agree to follow prescribed treatment plans and notify the clinic of any changes.
- I understand that medication refills require follow-up appointments as needed.
- I consent to the presence of supervised externs or students during my visit.

Patient Acknowledgment
I have read and understood the above policies. I agree to comply with Sunshine Specialty Healthcare's procedures and communication standards. I understand I may request a copy of this form and ask questions at any time.

Patient Signature : _____

Date : _____

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Patient Consent to Contact Form

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: _____

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WORK / SCHOOL EXCUSE

PATIENT NAME: _____ D.O.B.: _____
Please excuse the above-named patient from work / school due to being seen in our office.

The following restrictions have been given:

_____
_____
_____
_____

Patient is to return to work on:

_____

_____ _____
GIRON MD / NANDIKONDA MD / SANTIAGO MD DATE