



ELITE RHEUMATOLOGY AND ARTHRITIS CENTER

WE LISTEN. WE DIAGNOSE. WE HEAL.

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: _____