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

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 PREFERED: ____________________________________

PHARMACY PHONE NUMBER: _______________________________________

PHARMACY ADDRESS: ____

***We may place Rosemont Specialty Pharmacy on file for better coordination of specialty medications and biologic therapies, if needed ***

PREVIOUS/CURRENT PRIMARY PHYSICIAN NAME: _________________________

PRIMARY CARE PHONE NUMBER: ___________________________________

PRIMARY CARE FAX 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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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: ____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

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: ___________________

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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 NAME : _____________________________________ DOB : _____________

PATIENT SIGNATURE : ________________________________

DATE : ________________________

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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: ___________________

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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: ________________

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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: ____________________________________

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

- **Late Arrivals:** Patients arriving more than 5 minutes late to their appointment may be rescheduled at the clinic's discretion.
- **Telehealth Visits:** Telehealth appointments are available only with provider's 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.

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: ____

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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: ____ / ____ / _____

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Infections and Medical Symptoms-Testing Consent

Why your doctor may ask about past infections or order screening tests: Your care focuses on understanding the cause of symptoms such as joint pain, swelling, fatigue, rashes, or other health concerns. As part of this process, your provider may ask about past infections or recommend simple blood tests. This is a routine and standard part of care for many patients in both primary care and specialty settings.

Why does this matter? Some infections, both common viral infections and certain other infections—can affect the immune system. In some cases, they can Trigger the body to make autoantibodies (proteins that can sometimes target the body's own tissues), Cause symptoms that look similar to autoimmune or rheumatologic conditions and can Affect how certain medications should be used safely.

What kinds of infections are we talking about? These may include Viral infections such as hepatitis B, hepatitis C, HIV OR Other infections such as syphilis or similar conditions

Having one of these infections does **not** mean anything about a person's lifestyle or choices. These infections can occur in many different ways, including medical exposures, birth, or other non-personal factors.

Why am I being asked these questions? Your doctor may ask about past infections to: Make sure your diagnosis is accurate, rule out conditions that can mimic autoimmune diseases and Ensure that any medications prescribed are safe for you. These questions are asked in a routine, nonjudgmental way for all patients when appropriate.

Why are blood tests recommended? Screening tests help:

- Detect infections you may not know about
- Prevent complications if you need medications that affect the immune system
- Guide the safest and most effective treatment plan

What if I have never been tested before? That's completely okay. Many people have never been screened. Testing is simply a way to **gather important health information** and ensure your care is as safe and effective as possible.

Your privacy matters: All information you share and all test results are kept **confidential** and are used only to support your medical care.

Questions? Please feel free to ask your care team. We are here to support you.

Patient Acknowledgment

I understand that reviewing infection history and performing screening tests is a routine part of medical care and is important for accurate diagnosis and safe treatment.

Patient Name: ____ DOB: _____________

Signature: ____________________________ Date: __________

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