Sunshine Healthcare Solutions

Primary Care Specializing in You

Welcome to our Practice!

We are pleased you have chosen Sunshine Healthcare Solutions to be your Primary Care Provider. We are committed to providing you with the highest standard of medical care. We want to create a partnership to keep you healthy and active. We hope our relationship will provide open communication, listening as much as talking, and improved well-being.

We will review your medical history at each visit, but on your first visit, there is an especially detailed evaluation that we need filled out in its entirety.

Please complete and return below forms at least 24 hours prior to your initial visit.

Forms:

- **Medical Records Transfer**
- **New Patient Registration form**
- **HIPPA Form**
- **Advanced Beneficiary Notice**
- **New Patient Medical History**
- **Payment Policy Form**

You may fax the above forms to our office at 321-280-9499, mail, or drop off to the address below

You will need to bring the below documentation the day of your initial visit.

Necessary Documentation:

- **Insurance cards**
- **Picture ID**
- **Current Medication List**
- **Health Surrogate & Living Will**
- **Power of Attorney**
- **DNR**

Please arrive 30 minutes prior to your scheduled appointment. After your initial visit, you may receive a personal invitation to provide us with feedback about your experience at Sunshine Healthcare Solutions. Please take advantage of this opportunity as we are very interested in your opinion.

For a detailed look at our practice, policies, access to health forms, updates, and important health educational information, visit our web-site, www.sunshinehealthcaresolutions.com.

465 Minutemen Cswy # 455 • Cocoa Beach, FL 32931 • Phone (321) 574-6075
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New Patient Registration Form

(Please Print)

PATIENT INFORMATION			
Patient's First Name:	Middle name:	Last name:	
Patient Date of Birth:	Patient Sex: ☐ M ☐ F	Social Security no.:	Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other
Patient Email			
Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )	
Mailing address:	City:	State:	ZIP code:
If patient is a senior with a legal Power of Attorney , please give POA/guardian/parent names and specify relation to patient:			

IN CASE OF EMERGENCY			
Name of emergency contact person:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Mailing address:	City:	State:	ZIP code:
E-Mail address:			

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2nd Emergency Contact

Name:			
Relationship:	Phone:		
Mailing address:	City:	State:	ZIP code:

Statistical:

Language:	Race:
☐ English ☐ Spanish ☐ French ☐ German ☐ other _____	☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Black ☐ Asian ☐ Native American ☐ other
Current Living Situation: ☐ Independent ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Live with Family	Do You need an Interpreter? ☐Yes ☐No

Accouterments? (Check all that apply)

☐ Vision Impairment ☐ Hearing Impairment ☐ Impeded Mobility ☐ Immobile ☐ Difficulty Writing

☐ Cognitive Impairment ☐ Wheelchair ☐ Any Other _____

OTHER INFORMATION

Pharmacy name	Pharmacy location:	Pharmacy phone no:
Lab name:	Lab location:	Lab phone no:

May we notify you of appt. at your E-Mail address?:	☐Yes ☐No	May we leave voicemail messages of appointments on your answering machine?	☐Yes ☐No
May we notify you of test results at your E-Mail address?	☐Yes ☐No	May we notify you of test results on your answering machine?	☐Yes ☐No

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INSURANCE INFORMATION		
Name of primary insurance:	Policy subscriber's name, if not patient:	Policy subscriber's date of birth:
Policy Number:	Policy Effective Date:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		
Name of secondary insurance (if applicable):	Policy subscriber's name, if not patient:	Policy subscriber's date of birth:
Policy Number:	Policy Effective Date:	
Patient's relationship to subscriber: Self Spouse Child Other, please specify:		

Next of Kin			
First Name:	Middle Name:	Last Name:	
Mailing address:	City:	State:	ZIP code:
Phone number:	Relationship to patient:	Date of birth:	Place of birth

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Patient History

PRINT & COMPLETE: BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Name _____ *Age* _____ *Date of Birth* _____

Who are your other Healthcare Providers?

What is the reason for requesting this visit?

PAST MEDICAL HISTORY: Please list any medical conditions from which you have suffered in the past or currently:

PAST HOSPITALIZATIONS - SURGERIES: Please list any surgeries, or hospitalizations, reason & date:

ALLERGIES: *List any allergic reactions or adverse side effects you've had to any drugs or other*

Drug/Food/Item	Type of Reaction

CURRENT MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION: *List all over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.*

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS: *List all*

Herbal preparation	Dose	How often taken

FOR WOMEN ONLY:

Are you using any hormone based **Medication**	
When was your last menstrual period?	
Number of Pregnancies:	
Number of Births:	

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Patient History

TELL US ABOUT YOURSELF:

Home situation Single Married (how long_____) Divorced (how long_____) Widowed (how long_____)
Domestic partnership (how long_____)

Employment: Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation: _____

Habits:

Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____

Do you use alcohol? No_____Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? Y / N

Do you exercise regularly? No_____Yes_____
How often? _____/week What activity?_____ Minutes per session_____
Number of times you eat "fast food" per week? _____

Do you/have you used illicit drugs?	No	Yes
Do you have smoke detectors?	No	Yes
Do you where a helmet when riding a bike or motorcycle?	No	Yes
Do you use seatbelts?	No	Yes

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Immunizations: if YES, give approximate year given

Pneumococcal	No_____	Yes_____	**TB Test (PPD)**	No_____	Yes_____
H. influenza	No_____	Yes_____	**Zostavox (Shigles Shoot)**	No_____	Yes_____
Hepatitis B (series of 3)	No_____	Yes_____			
Tetanus booster	No_____	Yes_____			

FAMILY HISTORY: (Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)

	Maternal Grandparent	Paternal Grandparent	Father	Mother	Brother	Sister	Son	Dtr	Other
Colon or rectal cancer									
Breast or other cancer									
Stroke/Heart Attack before age 65									
Diabetes									
High blood pressure									
High cholesterol									
Alzheimer's Disease									
Alcohol/drug abuse									
Depression									
Bipolar Disorder									
Genetic disorder									
Other (Prostate ca, Ovarian Ca, Melanoma, Bleeding problems, Blood clots)									

Age of Parents: ____**Mother** Alive Deceased _____**Father** Alive Deceased
Number & Age of Children: **Healthy:** Yes No

- ☐ Are you experiencing an unusually stressful situation? Explain_____
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Explain:_____

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Patient History

SYMPTOM REVIEW

General

- ☐ change in weight: _____ lbs during last 6 months
- ☐ poor sleep
- ☐ fevers
- ☐ feeling depressed
- ☐ feeling forgetful
- ☐ night sweats or chills

Head, Eyes, ears, nose, throat

- ☐ headaches or migraines
- ☐ light headedness or dizziness
- ☐ bleeding gums
- ☐ blurred vision
- ☐ other change in vision
- ☐ dry eyes
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness or voice changes
- ☐ dentures: type _____

Cardiovascular

- ☐ chest pain
- ☐ palpitations or rapid heart beat
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat or murmur
- ☐ history of poor circulation
- ☐ Date/Result of last EKG_____
- ☐ Result of any other cardiac tests_____

Pulmonary/lungs

- ☐ shortness of breath
- ☐ difficulty breathing
- ☐ difficulty breathing lying down
- ☐ persistent cough
- ☐ sputum
- ☐ coughing up blood
- ☐ history of asthma or wheezing

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain or cramps
- ☐ bloating after meals
- ☐ indigestion
- ☐ difficulty swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ recent change in bowel habits
- ☐ nausea or vomiting
- ☐ vomiting blood
- ☐ rectal bleeding or blood in stools
- ☐ history of jaundice, liver disease or abnormal liver tests
- ☐ history of hemorrhoids
- ☐ history of colitis
- ☐ history of Hepatitis
- ☐ Date & result of last colonoscopy

_____

Genitourinary

- ☐ frequent urination
- ☐ inability to hold urine
- ☐ hesitancy during urination
- ☐ burning or painful urination
- ☐ blood in urine
- ☐ urinating at night
- ☐ **Recurrent Urinary Trace Infections**
- ☐ **Kidney Stones**
- ☐ Hx of STDs (eg: Syphilis, Gonorrhea, Herpes, HIV)

Muscle/joint/bone

- ☐ swelling of ankles or legs
- ☐ muscle aches, pains, or weakness
- ☐ joint aches pains or swelling
- ☐ **Fatigue or tiredness**
- ☐ **Osteoporosis**
- ☐ Have you ever fallen in last 2 years

Neurologic/Psychiatric

- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ numbness or tingling in fingers OR hands, OR feet
- ☐ leg cramps when walking
- ☐ leg cramps or movement at night
- ☐ **Seizures**
- ☐ Do you ever feel depressed or anxious or out of control
- ☐ History of suicide attempt

Skin

- ☐ Itching: where_____
- ☐ easy bruising
- ☐ new or change in moles
- ☐ eczema
- ☐ rashes
- ☐ lumps or bumps: **where**_____

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst
- ☐ excessive urination

Women only

- ☐ History of abnormal Pap smear
- ☐ History of bleeding between periods
- ☐ vaginal discharge
- ☐ breast discharge or lumps
- ☐ date of last mammogram_____
- ☐ date of last pap smear _____

Men only

- ☐ penile discharge
- ☐ impotence
- ☐ date of last PSA_____
- ☐ date of last prostate exam_____

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE (3 pages) TO YOUR APPOINTMENT

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We will be participating in most insurance plans, including Medicare. Our office is in the process of credentialing, usually a two month process. We will submit your insurance claim when this process is complete –up to 3 months from the time of your visit. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

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6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $50 for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____
Signature of Patient or Personal Representative

Date:_____

_____
Printed Name of Patient or Personal Representative

_____
Relationship to patient

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Sunshine Healthcare Solutions is required by law to maintain the privacy of your Protected Health Information ("PHI"). Sunshine Healthcare Solutions is further required to provide you with notice of Sunshine Healthcare Solution's legal duties and privacy practices with respect to PHI. PHI includes all individually identifiable health information concerning you which is either maintained by Sunshine Healthcare Solutions or transmitted by Sunshine Healthcare Solutions to others, whether in oral, written or electronic form. Please be assured that Sunshine Healthcare Solutions considers the maintenance of your privacy to be integral to its mission, and that Sunshine Healthcare Solutions has taken steps to guard against any improper use or disclosure of your PHI. The uses and disclosures of PHI are generally regulated by a federal law called the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA") and the regulations which were promulgated to enforce HIPAA. In instances where state laws relating to the privacy of PHI differ from HIPAA and a state law is either more protective of your PHI or provides you with greater access to your PHI, the state law overrides HIPAA.

Part I: Uses and Disclosures of PHI

1. Carrying Out Treatment, Payment and Health Care Operations

Except in an emergency or other special circumstance, before providing treatment to you, we will ask you to read and sign a written consent to allow us to use and disclose PHI for purposes of treatment provided to you, obtaining payment for services provided to you and for Sunshine Healthcare Solutions' health care operations (e.g., internal administration, quality improvement, and customer service), as detailed below. "Treatment" is the providing, coordinating or managing of your health care and related services. It includes consultations and referrals between one or more of your health care providers, such as doctors, nurses, therapists and technicians. Uses and disclosures of PHI for treatment purposes might include disclosures within Sunshine Healthcare Solutions or between Sunshine Healthcare Solutions and other providers. For example, a Sunshine Healthcare Solutions physician may refer you for care to another provider, including a specialist, in order to better assure continuity of care. Sunshine Healthcare Solutions may also use your PHI to contact you to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. "Payment" includes billing, collection and related services relating to seeking and obtaining payment from third parties (e.g., commercial insurance carriers and government payers like Medicare), and may involve communications relating to such activities as coverage determinations, claims processing, subrogation, reviews for medical necessity or appropriateness of care, and utilization review. Uses and disclosures of PHI for payment purposes may include communications with other health care providers if PHI is needed by the other providers to enable them to obtain payment for medical services provided to you. "Health care operations" include quality assessment and quality improvement activities, licensure and credentialing activities, and training of health care and non-health care professionals.

2. Other Uses and Disclosures of PHI Sunshine Healthcare Solutions may also use or disclose your PHI in the following circumstances:

(1) Disclosures to Relatives and Close Friends Involved in Your Care. Sunshine Healthcare Solutions may disclose PHI to a family member or friend involved with your care or with handling your bills if (a) you are present (or reasonably available to us) prior to the disclosure and you agree to the disclosure, or (b) we have provided you with an opportunity to object to the disclosure and you did not object, or (c) we may reasonably infer that you do not object to the disclosure (e.g., if family or friends are present while treatment is being provided and they are participating in discussions regarding treatment). If you are not present or available, and the opportunity for you to agree or object to a use or disclosure cannot practically be provided, Sunshine Healthcare Solutions may exercise professional judgment to determine whether a disclosure would be in your best interests. If information is disclosed to a family member or close friend, only that information which is relevant to that person's involvement with your treatment will be disclosed.

(2) Public Health Activities. Sunshine Healthcare Solutions may disclose PHI for the following public health activities and purposes: (a) to report health information to appropriate public health authorities for the purpose of preventing or controlling disease, injury or disability; (b) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (c) to report information about products under the jurisdiction of the U.S. Food and Drug Administration for quality, safety or effectiveness purposes; (d) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (e) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

(3) Victims of Abuse, Neglect or Domestic Violence. Sunshine Healthcare Solutions may disclose PHI to a government authority, including a social service or protective services agency authorized by law to receive such reports, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

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(4) Health Oversight Activities. Sunshine Healthcare Solutions may disclose PHI to a health oversight agency that oversees the health care system and ensures compliance with the rules of government health programs such as Medicare or Medicaid.
(5) Judicial and Administrative Proceedings. Sunshine Healthcare Solutions may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
(6) Law Enforcement Officials. Sunshine Healthcare Solutions may disclose PHI to the police or other law enforcement officials as required by law or in compliance with a court order.
(7) Decedents. Sunshine Healthcare Solutions may disclose PHI to a coroner or medical examiner as necessary to identify the deceased, determine the cause of death, or as otherwise authorized by law. Sunshine Healthcare Solutions may also disclose PHI to a funeral director as necessary to carry out the funeral director's duties, including arrangements after death.
(8) Organ and Tissue Procurement. Sunshine Healthcare Solutions may, in a manner consistent with State law, disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
(9) Research. Sunshine Healthcare Solutions may disclose PHI without your consent or authorization for research if an Institutional Review Board approves a waiver of authorization for disclosure and authorization is not required by law.
(10) Health or Safety. Sunshine Healthcare Solutions may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
(11) Specialized Government Functions. Sunshine Healthcare Solutions may disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.
(12) Workers' Compensation. Sunshine Healthcare Solutions may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
(13) Required by Law. Sunshine Healthcare Solutions may disclose PHI when required by federal, state or local laws.
Uses and Disclosures of PHI that Require Your Written Authorization Except as described in this Notice or Specifically required or permitted by law, Sunshine Healthcare Solutions will not use or disclose your PHI without your specific written, signed authorization. Even if you have signed an authorization, the authorization may be revoked by you, in writing, at any time, and once the authorization is revoked, Sunshine Healthcare Solutions may no longer use or disclose PHI for the purpose described in the authorization (unless, and to the extent that, Sunshine Healthcare Solutions has already taken action based upon the authorization).

Part 2. Your Individual Rights

a. Right to Request Restrictions on Uses and Disclosures of PHI If you wish, you may request that Sunshine Healthcare Solutions restrict its uses and disclosures of your PHI for the carrying out of treatment, payment or health care operations, or you may request that Sunshine Healthcare Solutions restrict uses and disclosures of your PHI to family members, relatives, friends or other persons identified by you who are involved in your care or the payment for you care. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Please note, however, that Sunshine Healthcare Solutions is not required to agree to your request.
b. Right to Request Alternate Method of Communication You have the right to reasonably request that Sunshine Healthcare Solutions communicate with you in specific ways or at specific locations, including in order to better ensure your privacy. Requests to receive communications by specific or alternative means or at specific or alternative locations should be made to the Sunshine Healthcare Solutions Privacy Officer at Sunshine Healthcare Solutions, 2070 US Hwy 1, Suite 102, Rockledge, FL 32855, (321) 396-7601.
c. Right to inspect and Copy PHI You also have a right to inspect and obtain a copy of your PHI to the extent that it is contained in a "designated record set." A "designated record set" includes: medical records and billing records, and other information used by or for Sunshine Healthcare Solutions to make decisions about your treatment. If you want access to your PHI, you will be required to complete a form and to submit the form to the Sunshine Healthcare Solutions Privacy Officer at Sunshine Healthcare Solutions, 2070 US Hwy 1, Suite 102, Rockledge, FL 32855, (321) 396-7601. Under some circumstances, Sunshine Healthcare Solutions may deny a request to inspect or obtain a copy of some information in a record. If access is denied, you will be provided with a written denial setting forth the basis for the denial and a description of how you may exercise review rights with respect to the denial.
d. Right to Amend PHI you have the right to request that Sunshine Healthcare Solutions amend your PHI or a record about you. If you desire such an amendment, you will be required to complete a request form, including a statement explaining the reason for the requested amendment, and to submit the request to the Sunshine Healthcare Solutions Privacy Officer at Sunshine Healthcare Solutions, 2070 US Hwy 1, Suite 102, Rockledge, FL 32855, (321) 396-7601. If the request is denied in whole or part, Sunshine Healthcare Solutions will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your PHI. Sunshine Healthcare Solutions may include a rebuttal statement with your PHI addressing your statement of disagreement.

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Acknowledgment of Receipt of Notice of Privacy Practices & Authorization
Consent to use & disclose health information (HIPAA)

I hereby acknowledge that the Practice has provided me its Notice of Privacy Practices ("HIPAA"). The Notice defines the terms "treatment", "payment" and "health care operations" and the types of uses and/or disclosures that the Practice can make if I execute this Consent. I have had the opportunity to review the Notice. I understand that the Practice may change the terms of the Notice from time to time, and that I may contact the Practice, at the address listed below, to obtain a revised version of the Notice at any time.

I also hereby authorize and consent to the use and/or disclosure of my protected health information so that I hear Sunshine Healthcare Solutions (the "Practice") can carry out treatment, payment and health care operations. For purposes of this document, protected health information means any and all information relating to health care services provided to me by the Practice including, but not limited to, information relating to services provided to me prior to this date.

I understand that I may submit a written request to the Practice asking that the Practice restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. I understand that the Practice is not required to agree to my requested restriction.

I also understand that this authorization/consent will remain in effect until I provide a written notice of revocation to the Practice. The revocation will be effective immediately upon the Practice's receipt of my written notice, although the revocation will not affect any actions the Practice took before it received my notice of revocation.

EMAIL SECURITY NOTICE: I understand that the use of email may compromise the security of my patient confidentiality.

I am aware of this risk and authorize communication in this manner. _____

I do not authorize communication in this manner. _____

_____
Signature of Patient or Personal Representative

Date:_____

_____
Printed Name of Patient or Personal Representative

_____
Relationship to patient

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Patient's Name _____ Medicare/Insurance # _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

Medicare/Insurance does not pay for all of your health care costs. Medicare/Insurance only pays for covered items and services when Medicare/Insurance rules are met. The fact that Medicare/Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare/Insurance may not pay.

I want to receive these items or services. I understand that Medicare/Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare/Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare/Insurance is making its decision. If Medicare/Insurance does pay, you will refund to me any payments I made to you that are due to me. If Medicare/Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare/Insurance's decision.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare/Insurance your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be kept confidential by Medicare/Insurance.

_____
Signature of Patient or Personal Representative

Date:_____

_____
Printed Name of Patient or Personal Representative

_____
Relationship to Patient

465 Minutemen Cswy # 455 Cocoa Beach, FL 32931 Phone (321) 574-6075
3150 N. Wickham Rd STE 7 Melbourne, FL 32935 Fax (321) 280-9499
www.SunshineHealthcareSolutions.com

Sunshine Healthcare Solutions

Primary Care Specializing in You

PHYSICIAN AUTHORIZATION FORM

_____ _____/_____/_____ _____ -_____-_____

PATIENT PRINTED NAME | Date of Birth | Social Security Number

I authorize the specified person(s) to disclose protected health information as follows:

1. **Person / Entity authorized to make disclosure:** _____
   (Name of health care provider)
2. **Person Authorized to receive the disclosed information:** Sunshine Healthcare Solutions
3. **Recipients fax #:** 321-280-9499
4. **Description of the protected health information that is authorized to be used or disclosed:**

☑ **Please send the 2 most recent visit notes**

☑ **Please send most recent complete labs and any recent diagnostic results**

The information will be used on my behalf for the following purpose(s):

The continuation of medical care and is not limited in any way.

I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician's clinic where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____

Signature **Date**

_____

Authorized Representative **Date**

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PHYSICIAN AUTHORIZATION FORM

_____ _____/_____/_____ _____ -_____-_____

PATIENT PRINTED NAME **Date of Birth** **Social Security Number**

I authorize the specified person(s) to disclose protected health information as follows:

1. **Person / Entity authorized to make disclosure:** _____
   (Name of health care provider)
2. **Person Authorized to receive the disclosed information:** **Sunshine Healthcare Solutions**
3. **Recipients fax #:** **321-280-9499**
4. **Description of the protected health information that is authorized to be used or disclosed:**

☑ Please send the most recent visit note

☑ Please send the most recent test results

The information will be used on my behalf for the following purpose(s):

The continuation of medical care.

5. **This authorization is not limited in any way.**
6. **I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.**
7. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician's clinic where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**

_____

Signature **Date**

_____

Authorized Representative **Date** **1 of 1**

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