# PATIENT REGISTRATION

| PLEASE PRINT AND COMPLETE ALL ENTRIES | | | |
|---|---|---|---|
| **PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)** | **ADDRESS** | | |
| **CITY, STATE** | **ZIP** | **HOME PHONE** | **CELL PHONE** |
| **DATE OF BIRTH** / **SSN** | **SEX** ❑ Male ❑ Female | **MARITAL STATUS** ❑ Single ❑ Married ❑ Widowed | |
| **EMAIL** | **PREFERRED CONTACT METHOD** ❑ Phone ❑ Email ❑ Text | **LANGUAGES SPOKEN** | |

| | | |
|---|---|---|
| **RACE** ❑ White ❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ Other ❑ Unknown ❑ Decline to answer | **ETHNICITY** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to answer | **NICKNAME (if preferred)** |

| INSURED/RESPONSIBLE PARTY INFORMATION | RELATION TO PATIENT: ❑spouse/partner ❑parent ❑Self | | |
|---|---|---|---|
| **NAME (Last -- First -- MIDDLE INITIAL)** | **ADDRESS (if different from patient)** | | |
| **HOME PHONE** | **SSN** | **BIRTH DATE** | ❑Retired ❑Unemployed |

| INSURANCE INFORMATION | | |
|---|---|---|
| **PRIMARY INSURANCE NAME** | **ADDRESS (STREET - CITY - STATE - ZIP)** | **PHONE** |
| **ID NUMBER** | **GROUP NUMBER** | |
| | | |
| **SECONDARY INSURANCE NAME** | | **PHONE** |
| **ID NUMBER** | | |

| OTHER INFO |
|---|
| **HOW DID YOU HEAR ABOUT US?** |
| **PREFERRED PHARMACY (ADDRESS & PHONE)** |

**Consent FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION**

I herby authorize Sunshine Physicians, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize Sunshine Physicians, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

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|---|---|
| ➡ **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** | **DATE** |
| **IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT** | **SIGNATURE OF WITNESS (Optional):** |

**PATIENT MEDICAL HISTORY**

**Patient Name**_____

**Allergies –** Please list any food or drug allergies

❑ None ❑ Penicillin ❑ Sulfa ❑ Dairy ❑ Other (Please specify)_____

**Past Procedures** - If any of the following were abnormal, please circle

❑ Colonoscopy (date_____) ❑ Bone Density (date_____) ❑ Mammogram (date_____)

❑ Pap Smear (date_____) ❑ Pregnancies (#_____)

**Family History – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.**

| | MOTHER ☐ Alive ☐ Deceased | FATHER ☐ Alive ☐ Deceased |
|---|---|---|
| Arthritis | | |
| Cancer (Type) | | |
| Diabetes | | |
| Heart Disease | | |
| High Cholesterol | | |

**SOCIAL HISTORY**

Do you drink **alcohol**? ☐**Yes** ☐**No**
☐ Daily ☐Weekly ☐ Occasional
☐ Recovering Alcoholic
Do you use **tobacco**? ☐**Yes** ☐**No**
☐ Smoke (___ packs per day)
☐ Past Smoker (When did you quit? _____)

**Surgical History** – Please list any hospitalizations, surgeries, fractures, or major illnesses that you have had

| TYPE OF SURGERY | YEAR or DATE | DOCTOR | LOCATION |
|---|---|---|---|
| | | | |
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**Medical History -** have you ever had any of the following?

| | |
|---|---|
| **Eyes** | ❑ Blindness Cataracts ❑ Glaucoma ❑ Glasses/contacts |
| **Ears** | ❑ Hearing Aids ❑ Ringing Hearing Loss |
| **Nose** | ❑ Allergic rhinitis ❑ Sinus infections |
| **Cardiovascular** | ❑ Angina ❑ CAD ❑ CHF ❑ DVT ❑ Dysrhythmia ❑ High cholesterol ❑ Hypertension ❑ Murmur ❑ Other heart disease |
| **Respiratory** | ❑ Asthma ❑ COPD ❑ Bronchitis ❑ Pleuritis ❑ Pneumonia |
| **Gastrointestinal** | ❑ Cirrhosis ❑ GERD ❑ Gallbladder disease ❑ Heartburn ❑ Hemorrhoids ❑ Hepatitis ❑ Hiatal hernia ❑ Jaundice ❑ Ulcer |
| **Genitourinary** | ❑ BPH ❑ ED ❑ Digestive Issues ❑ Diverticulitis ❑ Hernia ❑ Incontinence ❑ IBS ❑ Kidney stones ❑ Other kidney disease ❑ UTI(s) |
| **Musculoskeletal** | ❑ Arthritis (specify site)_____ ❑ Gout ❑ M/S injury (specify site)_____ ❑ Pain (specify site) _____ |
| **Skin** | ❑ Dermatitis ❑ Mole(s) ❑ Other skin condition(s) ❑ Psoriasis |
| **Neurological** | ❑ Trauma ❑ Epilepsy ❑ Neuropathy ❑ Seizures ❑ Severe headaches, migraines ❑ Stroke ❑ TIA |
| **Psychiatric** | ❑ Anxiety ❑ Bipolar disorder ❑ Depression ❑ Hallucinations, delusions ❑ Suicidal ideation ❑ Suicide attempts |
| **Endocrine** | ❑ Goiter ❑ Hyperlipidemia ❑ Hypothyroidism ❑ Thyroid disease ❑ Thyroiditis ❑ Type I DM ❑ Type II DM |
| **Heme/Onc** | ❑ Anemia ❑ Breast cancer ❑ Bladder cancer ❑ Colon cancer ❑ Prostate cancer ❑ Thyroid cancer ❑ Other |
| **Infectious** | ❑ HIV ❑ STDs ❑ Tuberculosis (dz) ❑ Tuberculosis (exposure) |
| **Other** | ❑ Chronic Fatigue Syndrome ❑ Fibromyalgia ❑ Insomnia ❑ _____ |

**Medication list – Medication Name** | **Strength and Frequency** | **Prescribing Doctor**

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**Patient Name:** _____

# Controlled Substance Policy

As of July 1, 2018, The State of Florida has instated new laws pertaining to prescribing controlled substances under the House Bill 21. Sunshine Physicians will be strictly adhering to these changes.

**All requests for controlled medications including pain medication/Opioids, anxiety and depression medications will follow the below policy.**

**New Patients:**

We will not prescribe any controlled medications including pain medication/Opioids, anxiety, or depression medications on the initial visit. On subsequent visits we will only prescribe according to the existing patient policy below.

**Existing Patients:**

1. All schedule II Opioids and pain medication may not exceed a 3-day supply for the treatment of acute pain with **NO** refills.
2. Patient's will be required to come in for an appointment when requesting any new prescriptions for these medications. If necessary, we will refer patient to pain management, appropriate specialist, or behavioral health for ongoing treatment of chronic issues.

Our office participates in the **Florida Prescription Drug Monitoring** program.

**ALL** requests for controlled substances **WILL** be verified through this National database.

Signature: _____ Date: _____

# Office Policies

**Patient Name**_____

Thank you for choosing Sunshine Physicians. We are committed to providing you with quality and affordable health care. This is an agreement between Sunshine Physicians and the Patient/Debtor named on this form. The word "account" means the account that has been established in your name to which the charges are made, and payments are credited. The words "we" and "our" refer to Sunshine Physicians by executing this agreement, you are agreeing to pay for all services that are received. A copy will be provided to you upon your request.

Please carefully read and initial each section below -

**Insurance**: We participate in a variety of insurance plans. Please provide us with your most current insurance information at the time of each visit to prevent unnecessary claims denials. If you are insured by a plan we are not participating with, payment in full is expected at the time of each visit. We will gladly provide you with an itemized statement of charges that you can submit to your insurer. If you are unable to provide us with a current insurance card, payment in full is required for services rendered until coverage can be verified. KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY, PLEASE CONTACT YOUR INSURANCE PROVIDER WITH ANY QUESTIONS YOU MAY HAVE REGARDING YOUR COVERAGE.

Int._____

**Co-payments, Deductibles and Coinsurance**: ALL co-payments, deductibles, and coinsurances must be paid at the time of service. This arrangement is part of our contract with our insurance provider. Failure on our part to collect co-payments, deductibles, and coinsurances from patients can be considered fraud. Please help us to comply with the law by paying co-payments, deductibles, and coinsurances each visit. THANK YOU.

Int._____

**Elective and Non-covered services:** Please be aware that some and perhaps all of the services you receive may not be covered by your insurance provider. Elective and Non-covered services must be paid for in full at the time of your visit.

Int._____

**Proof of insurance**: All patients must complete our Patient Information for PRIOR TO seeing the doctor. We must first obtain a copy of your VALID driver's license or state issued identification card and current valid insurance card so that coverage can be verified. Invalid or expired insurance information will result in the patient being responsible for payment of these services.

Int._____

**Claims Submission:** If we are a participating provider with your insurance carrier, we will submit all claims and assist you in any way to assure all charges are paid on your behalf. At times, insurance carriers will request additional information from the patient before processing a claim. Please be aware that failure to supply this information could result in claims denial therefore leaving the patient responsible for payment in full.

Int._____

**Coverage changes:** If your insurance changes, please notify us upon your arrival for your appointment to insure proper claims submission. It is your responsibility to confirm with your insurance carrier their laboratory of choice for any testing that may occur. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Int._____

**Cancelled/Missed Appointments:** Please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Our policy is to charge $40.00 for missed appointments that are cancelled less than 24 hours of your scheduled appointment time. New Patients who miss their first appointment will be subject to a No-Show Fee of $40.00. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Int._____

## Office Policies (cont.)

**Patient Name**_____

**Returned Check Fee**: There will be a $30.00 fee for checks written up to $300.00 or a $50.00 fee on checks written for $301.00 or over charged to your account for any returned items.

Int._____

**Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account IN FULL. Partial payments will not be accepted unless other arrangements are made with our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Int._____

**Past Due Accounts**: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of your balance to an attorney, you agree to pay all fees plus court costs incurred in the collection of the account. In case of suit, you agree that the venue be held in Port Orange, Florida.

Int._____

**Transferring of Records**: You will need to request, IN WRITING, any transfer of medical records. You understand that you may receive one (1) complimentary copy of your medical file to be transferred to a new physician in the event that you transfer your medical care. Any additional requests will result in a charge of $1.00 per page up to 25 pages and $.25 per page for each additional page. You further understand that medical record requests from other entities, such as attorneys, etc. will all be subject to the same charges. In the event that these entities do not cover the required charges, you understand that the charges will become your responsibility. If you are requesting records to be transferred from another physician or organization, you authorize us to send all relevant information, including payment history. Forms: Any forms filled out on your behalf will be subjected to a $20 fee per form, payable prior to picking up. We ask that you allow 7 days for processing. 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.

Int._____

**Courtesy**: Our goal is to provide the best medical care for our patients. We will try to make every effort to provide prompt on-time service. However, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. Please let us know if you have any suggestion or complaint for our office. Foul or angry language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

Int._____

**Electronic Prescriptions:** In compliance with State and Federal regulations Sunshine Physicians uses E-Prescribing for initial and refilling of all medications. As part of these guidelines you hereby authorize Sunshine Physicians to monitor your medications through outside sources such as, but not limited to, E-Forcse and Surescripts.

Int._____

Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party_____

Printed Name _____

Date _____

## Release of Information

| CONSENT TO SHARE INFORMATION & EMERGENCY CONTACT | | |
|---|---|---|
| I, _____ (print patient name), herby give my consent to speak with the following people in regards to my medical information. He or she may pick up prescriptions, lab or test results and medications on my behalf. | | |
| **NAME:** | **NUMBER:** | **RELATION TO PATIENT:** |
| **NAME:** | **NUMBER:** | **RELATION TO PATIENT:** |
| **NAME:** | **NUMBER:** | **RELATION TO PATIENT:** |
| **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:** | | **DATE:** |

## Privacy Policy/Protected Health Information

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

I hereby give my consent for Sunshine Physicians to use and disclose protected Health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices for Sunshine Physicians provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sunshine Physicians reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

With this consent, Sunshine Physicians may call my home or other alternative location and leave a message on voice main or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Sunshine Physicians may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confident."

I have the right to request that, Sunshine Physicians restrict how they use or disclose my PHI to carry out TPO. This request must be made in writing to our office. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to the use and disclosure of my PHI by Sunshine Physicians to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Sunshine Physicians may decline to provide treatment to me.

| **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:** | **PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE:** |
|---|---|
| **WITNESS:** | **DATE:** |

# Medical Records Release

Sunshine Physicians keeps a blank records release on file for you in case you require us to receive medical records on your behalf in the future.

**Please fill out the "Patient Information" section only and sign the bottom. Do NOT fill out the grey shaded area.**

If you have a specific doctor/facility you would like to request records from, we can print out this pre-filled form for your usage.

Thank you,

Sunshine Physicians

# Authorization to Release Medical Records

**Date:** _____

| PATIENT INFORMATION | | | |
|---|---|---|---|
| **PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)** | **ADDRESS** | | |
| **CITY, STATE** | **ZIP** | **HOME PHONE** | **CELL PHONE** |
| **PATIENT DATE OF BIRTH** | **PATIENT SSN** | **SEX** ❑ **Male** ❑ **Female** | |

**I authorize the following organization to release information as stated below from the patient health information record:**

| INFORMATION TO BE RELEASED FROM: | | | | |
|---|---|---|---|---|
| **ORGANIZATION** | | **STREET ADDRESS** | | |
| **CITY** | **STATE** | **ZIP** | **PHONE** | **FAX** |

| INFORMATION TO BE RELEASED TO: | | | | |
|---|---|---|---|---|
| **ORGANIZATION** Sunshine Physicians | | **STREET ADDRESS** 1730 Dunlawton Avenue, Suite 1 | | |
| **CITY** Port Orange | **STATE** Florida | **ZIP** 32127 | **PHONE** (386) 320-3299 | **FAX** (877) 991-1880 |

**INFORMATION TO BE REALEASED:**

**Dates of Service for Records Requested: Beginning (  ) Through (  )**

❑ **Entire Chart** ❑ **Labs** ❑ **Radiology** ❑ **Other Testing** ❑ **Clinic Notes** ❑ **Vaccination Record**

❑ **Other (Specify)**

**PURPOSE OF RELEASE:**

❑ **Continuing of Care** ❑ **Transferring to another provider** ❑ **Copies for own use** ❑ **Legal purposes**

❑ **Other (Specify)**

**AUTHORIZATION FOR GENERAL RELEASE INFORMATION:**

**This Authorization:**

❑ Is voluntary and is not required for obtaining treatment of payment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits.

❑ Will expire in 12 months from the date signed below unless another date or event is entered here (  )

(Note: If the disclosure is to an employer or financial institution, this authorization will expire in 90 days from the date you signed)

❑ May be revoked at any time by writing to Sunshine Physicians, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected.

**The following sensitive records require specific patient authorization. Please Check the applicable box below to request the following records:**

❑ Sexually Transmitted Diseases ❑ AIDS/HIV ❑ Alcohol/Drug Abuse Treatment ❑ Mental Health Treatment

**WARNING**: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.

**Release**: I release Sunshine Physicians, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization

| SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: | |
|---|---|
| **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** | **DATE** |