Sunshine Rheumatology New Patient Information

NAME:_____
(LAST) (FIRST) (MIDDLE INITIAL)

BIRTHDATE:_____ AGE:_____

ADDRESS:_____ CITY:_____ STATE: _____ZIP:_____

EMAIL ADDRESS: _____HOME TEL # _____

CELL PHONE #_____ MARITAL STATUS S_____M_____W_____D_____

REFERRING DOCTOR: _____PRIMARY CARE PROVIDER: _____

OK TO LEAVE detailed telephone messages regarding your personal health: (Circle) YES NO

You can disclose my Health information to : _____ Relation: _____

IN CASE OF EMERGENCY NOTIFY:_____ RELATION:_____TEL#: _____

IF SPOUSE IS POLICY HOLDER : NAME OF SPOUSE:_____ BIRTHDATE_____

Financial Policy : As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. **If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you.**

Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Patient Initial_____

Financial Arrangements: Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment. **Patient Initial_____**

Appointments/Cancellations: We gladly reserve appointment times for you and appreciate that you have chosen Sunshine Rheumatology for your care. As a courtesy, we will remind you of your appointment by **calling and/or text/emailing** you **2/3** days prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. **We reserve the right to charge $25**

for regular appointments and 75$ for New patient appointments cancelled or broken without advance notice of 2 business days. **Patient Initial_____**

Assignment and Release: I authorize payment to be made directly to Sunshine Rheumatology by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize the release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information. **Patient Initial_____**

Credit Card on File Policy : Sunshine Rheumatology is committed to making our billing process as simple and easy as possible. We suggest that all patients provide a credit card on file with our office. We will save your card in a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file can be used to pay copays when you are seen in our office. It can also be used to pay outstanding account balances, after your insurance processes your claim.

Patient Initial _____

Late Payment Policy: If we do not receive payment for the amount listed on your statement within 60 days of the statement date**,** we will give you a courtesy call reminding you of your outstanding balance. **If our reminder call is not returned within one week with a payment arrangement, a $35 late payment fee will be charged and another statement will be mailed. Your account becomes delinquent if not paid within 45 days after the date of the original statement. I give Sunshine Rheumatology permission to charge my credit card on file for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.** **Patient Initial_____**

Medication Refills: We request that patients get their medications refilled at the time of their appointments or, when necessary, to call a prescription into their pharmacy several days in advance of running out of medication. We suggest refilling medications electronically through your pharmacy rather than calling the office. Pharmacy can request us refills electronically. Patients **should have a future appointment** and **should have seen the physician within the last 3-6 months** and had **appropriate blood work** done to **request refills or it may be denied.**

Fibromyalgia Referrals: Sunshine Rheumatology will continue to accept referrals for Fibromyalgia patients **to evaluate and rule out any underlying autoimmune disease but it's important to note that we will refer Primary Fibromyalgia (without underlying autoimmune disease) patient back to PCP /Psychiatrist for Management.**

HIPAA/Patient Consent Policy : Notice of Privacy Practices Written Agreement: I have read a copy of Sunshine Rheumatology Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Sunshine Rheumatology has a link to the Notice of Privacy Practices on the practice website located at https://www.sunshinerheumatology.com/notice-of-privacy

Name (please print): _____ Date:_____

Signature of Responsible Party (Guarantor):_____

Relationship to Patient(s) (please check): ___ Self ___Other:_____