Sunshine Family Medicine Inc.

PATIENT INFORMATION

Patient Name: _____

Mailing Address: _____

City/State/Zip: _____

Date of Birth: _____ Gender: M / F SS # _____

Phone: Home # _____, Work # _____, Mobile # _____

Spouse / Parent's Name _____

Emergency Contact Name and Phone # _____

Preferred Pharmacy: _____

PRIMARY INSURANCE Employee Use Only

Insurance Company _____

Person Responsible for Account _____
Last First MI

Relationship to Patient: Self / Spouse / Parent Birthdate _____ SS# _____

Person Responsible Employed by _____ Business Phone _____

ADDITIONAL INSURANCE Employee Use Only

Is patient covered by additional insurance? YES NO

Insurance Company _____

Person Responsible for Account _____ Phone _____
Last First MI

ASSIGNMENT & RELEASE (Must be signed)

I, the undersigned certify that I (or my dependant) have insurance with _____ and assign directly to **Sunshine Family Medicine Inc**. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Sunshine
Family Medicine Inc.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Sunshine Family Medicine, Inc. (SFM) 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 provided by SFM describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. SFM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sunshine Family Medicine, Inc., 115 South Gloria Street, Clewiston, FL 33440.

With this consent, SFM may call my home or other alternative location and leave a message on voice mail 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 test results, among others.

With this consent, SFM 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 Confidential."

I have the right to request that SFM restrict how it uses or discloses my PHI to carry out TPO. 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 allow SFM to use and disclose my PHI 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, SFM may decline to provide treatment to me.

Signed by: _____ Date: _____

Relationship to Patient: _____

Print Patient's Name: _____

Print Name of Legal Guardian, if applicable: _____