

Patient Information Sheet

PERSONAL INFORMATION

First Name	Middle Name	Last Name		
_____ / _____ / _____				
Nickname	Birth Date (mm/dd/yyyy)	Gender		
_____ / _____ / _____				
Social Security Number	Marital Status	Driver's License Number	State	Expiration
(_____) _____	(_____) _____	(_____) _____		
Home Telephone	Work Phone	Cell Phone/Other		
_____			_____	_____
Address	City	State	Zip Code	

Email Address				

EMPLOYMENT / GUARANTOR

_____		(_____) _____	
Employer		Phone	

Employer's Address	City	State	Zip Code
_____			_____
Guarantor's Name (when applicable)	Guarantor's Social Security #	Relationship to Patient	

INSURANCE

_____		(_____) _____	
Insurance Company		Phone Number	

Policy Number	Group Number	Policy Holder	

Policy Holder's Address (if different)	City	State	Zip Code

EMERGENCY & PHARMACY INFORMATION

_____		(_____) _____
Emergency Contact (Name)	Relationship To Patient	Phone Number

Pharmacy Name	(_____) _____	(_____) _____
	Phone	Fax

Sunny Medical PL LLC

11183 S. Orange Blossom Trl. Ste. D

Orlando, FL. 32837

Ph: 407-850-0103 Fax: 407-850-9901

REQUIRED DEMOGRAPHICS INFORMATION:

As part of the new healthcare reform act, **The US Department of Health and Human Services** has embarked on an initiative to standardize the collection of data on race and ethnicity in an effort to produce better reporting on treatment and standards. As part of this initiative, the **information we are requesting is now mandatory** for the Standardization for Health Care Quality Improvement. For complete information on Standardization for Health Care Quality Improvement, please visit the following webpage at the US Department of Health and Human Services:

<http://www.ahrq.gov/research/iomracereport/reldatasum.htm> .

What is Required?

The Practice is REQUIRED to collect this information from patients and to use it solely for reporting purposes

The Patient is REQUIRED to select an option provided - even if this option is "Declined".

Please Complete the Sections Below Fully:

RACE:

(Please check ONE Box)

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Race |
| | <input type="checkbox"/> Declined |

ETHNIC GROUP: *(Please check ONE Box)*

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> NON-Hispanic or Latino | <input type="checkbox"/> Declined |
|---|---|-----------------------------------|

PREFERRED LANGUAGE: *(Please check ONE Box)*

- | | | | | |
|-----------------------------------|----------------------------------|----------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian | <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other |

Patient Name Printed

Signature

Date

Financial Policy Statement

APPOINTMENT TIMES: We reserve your appointment time for you alone. Thus, we respectfully ask that you give us at least 24 hours' notice prior to canceling or rescheduling your appointments so that we may offer your appointment to another patient who may need to see us. If not, you will be subject to a **\$25** charge.

HEALTH PLANS: All health plans are not the same and do not cover the same services. Patients are responsible for knowing the benefits of their individual insurance plans and any referral requirements necessary to have coverage of any service rendered. Should you not know this, please contact your Health Plan using information usually provided on your insurance card.

INSURANCE COVERAGE:

1. Patients With Insurance Plans in Which We Participate:

Please verify your eligibility and benefits prior to your visit. Patients are responsible for deductibles, co-pays, non-covered services, co-insurance, and items considered "not medically necessary" by your insurance company. **Payment of your co-pay and/or co-insurance is due at the time of service; if you are not able to remit payment, we may request you to re-schedule your appointment.** Additionally, any balances due after your insurance processes your claim will be due within thirty (30) days of notice from the insurance company. You are also responsible for ensuring that your insurance recognizes us as your new primary care physician, if required.

2. In-Network/Out of Network Verification:

Patients are advised to contact their insurance companies before-hand if you would like to verify whether your provider/providers are in network. Our office will use tools available to us to determine, in good faith, if your insurance plan is in network with our provider/providers. If, on filing your claim, your insurance plan determines our provider/providers are out of network, any balances that have been placed as your responsibility for payment will be due in full within 30 days or will be subjected to the terms of our outstanding balance policy.

3. Patients With Insurance Plans in Which We DO NOT Participate:

Full payment is due at the time of service. Upon request, we may provide you with your visit information from which you can file a claim on your own behalf.

4. Private Pay Patients:

Full payment is due at the time of service. We will provide you with a receipt for your records.

OUTSTANDING BALANCES: We request that you remit all outstanding balances, including no-show charges, within thirty (30) days of date of service or charge date. If you are unable to meet this commitment your account will be considered delinquent. If your account becomes severely delinquent, it will be referred to a collection's agency and any charges and/or fees incurred in this process will be added to your balance.

MINORS: Parents or guardians with custody must accompany all minors for their appointments and will also be responsible for remitting payment for all services rendered to the minor patient(s).

AGREEMENT: I have read and understand the financial policy of the practice and I agree to follow its terms. I also understand that this policy may be amended from time to time by the practice. If necessary, I have contacted my insurance company and verified that **Emily Vives MD** is designated as my new primary care physician.

Patient Signature

Date

Guarantor or Responsible Party for the patient

Relationship to patient

Address (If Guarantor for patient)

City / State / Zip

Phone (Include Area Code)

Sunny Medical PL LLC
11183 S. Orange Blossom Trl. Ste. D
Orlando, FL. 32837
Ph: 407-850-0103 Fax: 407-850-9901

Authorization to obtain, release or review protected health information

I, _____ hereby authorize Sunny Medical Family Practice to
Patient/Legal Representative

obtain copies of protected health information of: _____
Print Patient's Name

FROM: _____
Name of Individual, Healthcare Facility or Agency Phone Fax

Address City State Zip

PLEASE SEND RECORDS TO:

Sunny Medical PL LLC.
11183 S. Orange Blossom Trl. Suite D,
Orlando FL.32837
PH: (407) 850-0103 | FAX: (407) 850-9901

Dates of services: From: _____ To: _____

Please place your INITIALS by each/all item to be released:

_____ All Chart / Visit Notes _____ Consultations
_____ Labs _____ Radiology _____ Other (*Specify*)

Additionally, please specify by INITIALS each/all applicable items:

_____ Mental Health _____ HIV Testing _____ Drug and/or Alcohol _____ AIDS Information

Date of Birth

Social Security Number

Address City State Zip

Patient/Legal Representative/ Parent Signature

Date

Witness

Patient Health History Form

Name: _____ Birthdate: _____

Drug Allergies YES NO (If "YES", please list)

Current Medications (please include non-prescription drugs and herbal remedies):

Name of Medication	Dosage	How Often Taken
--------------------	--------	-----------------

Please provide details if you or a family member have had any of the following medical conditions:

Cancer (specify type) _____

Depression or Suicide _____

Diabetes _____

Heart Problems _____

High Blood Pressure _____

High Cholesterol _____

Lung Problems _____

Sickle Cell _____

Stroke _____

Thyroid Problems _____

Any Other Problem(s) _____

Females please indicate:

Number of pregnancies _____

Number of live births _____

First day of last period _____

Sunny Medical PL LLC

11183 S. Orange Blossom Trl. Ste. D

Orlando, FL. 32837

Ph: 407-850-0103 Fax: 407-850-9901

Please list any surgeries you have had (use back of sheet if necessary)

(Continued on back of page)

Marital or Partnership Status: _____ **Occupation:** _____

I drink alcohol _____ times per day, _____ times per week.

I smoke _____ cigarettes (or cigars, pipes etc.) a day.

I exercise _____ minutes per day, _____ times per week.

Please indicate year of your last:

Tetanus Booster _____

DEXA Scan _____

Pneumonia Shot _____

Cholesterol _____

Colonoscopy _____

PAP smear _____

Mammogram _____

Complete Physical Exam _____

Sunny Medical PL LLC

11183 S. Orange Blossom Trl. Ste. D

Orlando, FL. 32837

Ph: 407-850-0103 Fax: 407-850-9901

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Sunny Medical Family Practice, PL LLC. (Hereafter referred to as "the Practice") in order to carry out treatment, payment, or health care operations. (You should review and may request, at any time, a copy of the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.).

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: *(list below)*

I agree that the Practice may also disclose the following types of information contained in my medical record:
(Please initial the appropriate categories listed below)

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s)
(Please initial the appropriate spaces below):

_____ **Via e-mail** to the Patient's designated e-mail address: _____
(I am responsible for notifying the practice of any changes to my e-mail address.)

_____ **Via postal mail** with any envelopes being marked personal and confidential and addressed to me.

_____ **Via telephone**, if I contact the Practice and provide the appropriate information *(Including my name, social security number and unique personal identifier)*.

_____ **Via fax** to my designated **secure** fax number: _____

Sunny Medical PL LLC

11183 S. Orange Blossom Trl. Ste. D

Orlando, FL. 32837

Ph: 407-850-0103 Fax: 407-850-9901

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice **in writing**. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM PM

Signature of Patient or authorized representative

Please print Name

Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

Sunny Medical PL LLC

11183 S. Orange Blossom Trl. Ste. D
Orlando, FL. 32837
Ph: 407-850-0103 Fax: 407-850-9901

Patient Office Conduct Policy

I understand that I am fully responsible for my behavior and the behavior of anyone that accompanies me to Sunny Medical PL LLC. Any inappropriate behavior or language directed to the physician(s) and/or office staff within the office or during telephone conversations will not be tolerated and may result in my discharge from the practice.

I understand that as a patient of **Sunny Medical Family Practice, P.L LLC.**, I agree to abide by all office policies.

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or the patient's authorized representative, to release Dr. Emily Vives. and/or members of Sunny Medical Family Practice, P.L.LLC. staff from any and all liability which may arise from this action, whether or not foreseen at present.

Signature of patient/authorized representative

Date