PATIENT CONSENT FOR COMMUNICATION

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office and to provide general health reminders/ information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Sunshine Medical Centers. _____ (initial)

2. I consent to receive text messages from Sunshine Medical Centers on my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: ( ) _____ - _____ Carrier: _____ _____ (initial)

3. I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is: _____ _____ (initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. _____ (initial)

PATIENT CONSENT TO TREAT: I hereby authorize the Doctors/Nurse Practitioners of Sunshine Medical Centers to treat my case as they deem appropriate through the use of lab testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing. I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves.

It is understood and agreed the amount paid to the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Sunshine Medical Center's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____ DOB: _____

Signature of Patient/Personal Representative: _____

Documentation of Good Faith Effort to Obtain Written Acknowledgement:

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the patient, the Notice of Privacy Practices posted in our office
- ☐ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment of service
- ☐ Giving the patient all the necessary information to obtain our Notice of Privacy Practices on our website
- ☐ Asking the patient to sign this Acknowledgement form
- ☐ Other (explain in detail)

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice
- ☐ Other (explain in detail)

Date: _____ Name: _____