**Nauman Salim, MD**
*Board Certified Allergist & Immunologist for Adults & Pediatrics*

**Samia Malik, MD**
*Board Certified Neurologist*

## NEW PATIENT INFORMATION

NAME/NOMBRE: ____________________________________________________

DATE/FECHA: ________________

D.O.B/FECHA DE NACIMIENTO: __________________

EMAIL/CORREO ELECTRONICO: _____________________________________________________

Health Insurance name/Nombre de Seguro medico: ___________________________________________

Health Insurance ID number/Numbero de poliza: _____________________________________________

Primary Care Provider name and phone number/nombre de doctor primario y numero de telefono:
_____________________________________________________________________________________

______________________________________________________________________________________

Preferred pharmacy/ Farmacia preferida:
______________________________________________________________________________________
______________________________________________________________________________________

Pharmacy Address/Direccion de farmacia:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

What is the reason for the visit? Que es la razon por esta visita?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

What are your expectations from this Neurology consultation? Que esperas de esta consulta? __________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Weight/Peso: ________ Height/Estatura: _______

**Westchase: 13692 W. Hillsborough Ave Tampa, FL. 33635 Carrollwood: 16598 N Dale Mabry Hwy Tampa, FL. 33618**

**Trinity: 2445 Country Place Blvd Suite #102 New port Richey FL. 34655**

**Phone: 813-252-2375 Fax: 813-324-5680 E-mail: sunshineallergyasthma@gmail.com**

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Blood pressure/ presion de sangre: ___________

CURRENT MEDICATION/MEDICAMENTOS UTILIZADOS

| MEDICATION NAME/NOMBRE DE MEDICAMENTO | DOSAGE AND FREQUENCY/DOSIS Y FREQUENCIA |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

MEDICATION ALLERGIES/ALLERGIAS A MEDICAMENTOS

| MEDICATION NAME/NOMBRE DE MEDICAMENTO | REACTION/REACCION |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

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Dear Patient,

- We, Sunshine Medicine Associates, will not be able to provide any office chart, office visit notes and medical records to any third party except to a government agency or insurance agency. / Nosotros, Sunshine Medicine Associates, no podremos proporcionar ningún gráfico de consultorio, notas de visitas al consultorio ni registros médicos a ningún tercero, excepto a una agencia gubernamental o agencia de seguros.

- We absolutely do not provide any medical service to social security dispute claim, workmen's compensation and auto-accidents. /Absolutamente no brindamos ningún servicio médico para reclamos de disputas de seguridad social, compensación de trabajadores y accidentes automovilísticos.

- We will not be able to provide documentations related to our visit to anyone except patient themselves or primary care provider who referred patient to us. /No podremos proporcionar documentación relacionada con nuestra visita a nadie, excepto al propio paciente o al proveedor de atención primaria que nos refirió al paciente.

- There will be a charge of $50 charge flat fees for printing medical records which will be given to patient themselves in person. / Se cobrará una tarifa fija de $ 50 por imprimir registros médicos que se entregarán al paciente en persona

- I completely understood and acknowledged the above mention information. I agree to comply with the practice's policies and regulations regarding it. / Entendí completamente y reconocí la información mencionada anteriormente. Acepto cumplir con las políticas y regulaciones de la práctica al respecto.

Name/Nombre: ______________________________________________________________________________

Signature/Firma: ______________________________________________________________________________

Date of birth/Fecha de nacimiento: _________________ Date/Fecha: _______________________

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Sunshine Medicine Associates
Advancing Medicine. Touching lives.

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# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME / NOMBRE DE PACIENTE:

______________________________________________________________________________
______________________________________________________________________________

DATE OF BIRTH/ FECHA DE NACIMIENTO:

______________________________________________________________________________
______________________________________________________________________________

ADDRESS/DIRECCION:

______________________________________________________________________________
______________________________________________________________________________

I, ________________________________ hereby authorize and request you to release the following protected health information to Sunshine Medicine Associates the office of Nauman Salim M.D. and Samia Malik M.D.

The patient information being requested may not be further disclosed to any party under any circumstances except with the patients express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

Yo, ___________________________________ autorizo y solocito que divulgue la siguiente informacion medica protegida a Sunshine Medicine Associate la oficina de Nauman Salim M.D. y Samia Malik M.D.

La informacion del paciente que se solicita no puede ser divulgada a ninguna parte bajo ninguna circunstancia excepto con el consentimiento por escrito del paciente o lo permita la ley. La informacion no se puede utilizar excepto para la necesidad especificada.

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Signature/Firma________________________________________Date/Fecha: ______________________________________

## Patient Financial Responsibility Form

Thank you for choosing Sunshine Medicine Associates, as your health care provider. We are honored that you selected us, we are committed to providing you with the highest quality healthcare. We do ask that you read and thoroughly understand before signing the following acknowledgment of our patient financial responsibility:

- Patient is ultimately responsible for the payment of his/her treatment and care by our facility.
- Patient is responsible for any costs associated with collection of patient balances.
- Patient is responsible for all copayments and coinsurance of patients' balances
- Patient is made fully aware that failure to pay for his/her treatment and care will result in collection actions being taken to settle the debt
- Medical records: $1 per page for the first 25 pages and $0.25 per page for each additional page

Do you have an HSA account? Yes _________ No__________

Do you currently have your HSA card with you? Yes __________ No__________

Patient Authorizations:

- My signature shows that, I hereby authorization assignment of financial benefits directly to Sunshine Medicine Associates and all associated healthcare entities for services rendered as allowed under third party contracts. I understand and take full financial responsibility for my patient account, all associated fees and balances my care may accrue and give my consent.

I have read, understand, authorization and agree to all the provisions of this patient financial responsibility form.

Print patient name: ____________________________________________________________________

Patient or guardian signature: ____________________________________________________________

Address: ______________________________________________________________________________

Phone number: _________________________________________________________________________

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## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether the subject of any existing court action, shall also be resolved by arbitration.
Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provision of Florida law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.
Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the Fl Code of Civil Procedure provisions relating to arbitration.
Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services. ______________________________
Patient’s or Patient’s Representative’s Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

| ___________________________ | __________________ | ___________________________________ | _______________ |
|---|---|---|---|
| Physician’s Authorized Representative’s Signature | Date | Patient’s or Patient’s Representative’s Signature | Date |

______________________________________________________________
Print Patient’s Name
(If representative, print Name and Relationship to Patient)

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