Perez Neurology
2695 S LeJeune Road
Suite 200
Coral Gables, FL 33134
P: 305-529-5558
F: 305-529-5854
perezneurologymanager@gmail.com
www.perezneurology.com

PEREZ NEUROLOGY

Patient Responsibility Form

Patient Information:
Name: _____
DOB: _____

I, the undersigned patient or legal guardian of the patient named above, hereby acknowledge and agree to the following terms and responsibilities regarding the medical services provided by Perez Neurology:

1. Financial Responsibility:
   - I understand that I am financially responsible for all medical services rendered, including but not limited to consultations, treatments, procedures, and medications, not covered by my insurance plan.
   - I agree to provide accurate and up-to-date insurance information and to promptly inform the practice of any changes in my insurance coverage.

2. Insurance Coverage:
   - I understand that insurance coverage varies and that certain services may not be covered by my insurance plan.
   - I agree to contact my insurance provider directly to verify coverage and understand any applicable copayments, deductibles, and coinsurance amounts.

3. Payment Obligation:
   - I agree to pay any copayments, deductibles, coinsurance, or outstanding balances at the time of service unless other arrangements have been made with the practice.
   - I understand that failure to pay outstanding balances may result in additional fees and may be subject to collections action.

4. Appointment Cancellation:
   - I understand that I am responsible for canceling or rescheduling appointments at least 24 hours in advance to avoid a cancellation fee, except in cases of emergencies or unforeseen circumstances.

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5. Compliance with Treatment Plans:
   - I agree to follow the treatment plan prescribed by my healthcare provider, including taking medications as directed, attending follow-up appointments, and adhering to lifestyle recommendations.

6. Communication:
   - I understand the importance of timely communication with my healthcare provider and agree to promptly inform the practice of any changes in my medical condition, medications, or concerns regarding my treatment.

7. Medical Records:
   - I authorize the release of my medical records to authorized individuals or entities involved in my care, including other healthcare providers and insurance companies, as necessary for treatment, payment, or healthcare operations.

8. Patient Rights:
   - I acknowledge that I have been provided with information regarding my rights as a patient, including the right to privacy, informed consent, and access to my medical records.

9. Agreement to Terms:
   - By signing below, I acknowledge that I have read and understand the terms and responsibilities outlined in this form. I agree to abide by these terms and accept financial responsibility for all services rendered.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Please retain a copy of this form for your records. If you have any questions or concerns regarding these terms, please do not hesitate to contact our office.

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