SUNRISE NEUROLOGY P.A.
38156 MEDICAL CENTER AVE
ZEPHYRHILLS, FL 33540
PH: 813-783-9799 FAX: 813-783-9793

PATIENT'S NAME:_____

DATE OF BIRTH: _____

I undersigned hereby affirm and agree that:

1. My visits to Sunrise Neurology P.A. are not related to personal, automobile, slip, fall and work-related injuries, disability and medico-legal claims.
2. I do not carry any other insurance through my spouse and anyone else, other than reported at the time of service. I am responsible to notify immediately any change in insurance status.
3. I understand the nature of neurology practice and agree to hold harmless Sunrise Neurology P.A. / Prakashkumar Patel, M.D. in any litigation and lawsuit. I understand that I will be discharged without further notification in the event I fail to abide by the agreement.
4. I will be responsible for all legal expenses including attorney fees incurred by Sunrise Neurology PA for any litigation and to recover any unpaid balance.
5. Service charge of 2% per month (24% annually) will be added on all balances over 30 days past statement due.
6. I will be charged $25.00 for NO SHOW.
7. I understand that Sunrise Neurology PA / Dr. Prakashkumar Patel is not responsible for authorization for office visits, medications, and imaging and any diagnostic studies.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES FORM

Our notice of privacy practices provides information about how we may use, and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change without further notification. If we change our Notice, you may obtain a revised copy by writing to our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information, about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

SIGNATURE: _____

DATE: _____

Revised 10/20/2021