COASTNEURO
2 James Way, Suite 101 Pismo Beach, CA 93449

# DISCLOSURE AUTHORIZATION & FINANCIAL RESPONSIBILITY STATEMENT

1. I authorize CoastNeuro to contact me in the following manners:

   ☐ **By Phone** ☐ **By Mail** ☐ **Other:** _____

2. I understand that I am financially responsible for payments in full of all accounts (with the exception of industrial injuries, Medi-Cal, or other fully sponsored government accounts). I hereby authorize my physician to release records to other physicians and legitimate requesting sources. I authorize payments of medical benefits to my physicians or suppliers for services rendered. A photocopy of this authorization and assignment of benefits shall be as valid as the original.

   **Initial:** _____

3. I understand that I am required to give at least one full business day's notice, by phone, to reschedule or cancel my appointments with CoastNeuro. (For example, if my appointment is 9am Monday, I am required to call by 9am the previous Friday.) If I reschedule or cancel my appointment with less than one full business day's notice, or if I do not show up for my scheduled appointment, I understand that I must pay a late-cancellation fee, not covered by medical insurance, before I am allowed to reschedule my appointment.

   **Initial:** _____

4. I understand that if I become involved in litigation that requires my physician to spend a significant amount of time dealing with my legal issues (speaking to attorneys, completing legal paperwork, etc.), I will be billed for the time my physician spends on my behalf, even if my insurance does not cover these costs.

   **Initial:** _____

_____ _____

**Patient or Guardian Signature** **Date**

The most current version of this form is always available at www.coastneuro.com.