



**PATIENT RESPONSIBILITY FORM**

**Patient Responsibilities**

- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered services.
- Co-payments are due at time of services
- If my plan requires a referral, I must obtain one prior to my visit.
- In the event that my health plan determines a service to be “Not Payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided.
- I must provide you with **ANY** additional insurance information that necessitates accurate and efficient payment. I must provide this on or before my initial visit and during the course of my ongoing treatment.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service. **(These fees are \$100.00 for Evaluation and \$75.00 for follow up visits).**

**Insurance Authorization for assignment of Benefits**

I hereby authorize and direct payment of my medical benefits to Desire.Sante (DBA- Mirasol Physical Rehab Center) on my behalf for any services furnished to me by the providers.

**Authorization to Release Records**

I hereby authorize Desire.Sante (DBA-Mirasol Physical Rehab Center) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for each medical services, as well as information required for precertification, authorizations, or referral to other medical providers.

**Medicare Request Payment**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Desire.Sante(DBA-Mirasol Physical Rehab Center). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine benefits or benefits for related services.

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 Signature of Patient, Authorized Representative or Responsible Party

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 Date