



FINANCIAL AGREEMENT AND POLICY

I am hereby opening an account at Arthroscopic Surgery Associates. I realize this is necessary because payment for medical care may not be timely due to insurance delays or disputes. I will assist Arthroscopic Surgery Associates in securing payment from my carrier if need be, but I am ultimately responsible for deductible, percentage or co-payment not covered by my insurance. I agree to pay the above in full at the time of each visit.

If I am a new patient to this clinic and I do not have medical insurance, I agree to pay the full cost of each visit at the time of service. If this is not possible, I understand that I may speak with the Billing Department to see if payment arrangements can be made before I am seen by the doctor each date of service. I authorize Arthroscopic Surgery Associates to request a credit report in order to establish payment stability.

I am responsible to provide all current, accurate insurance information and any change of address to Arthroscopic Surgery Associates Billing Department so they can bill my insurance without delay.

If I have made payment arrangements and have an outstanding balance, I understand that my payment is due and payable upon receipt of my monthly statement. A payment is required each month in order to properly maintain my account. Non-payment on my account while awaiting insurance payment is not acceptable.

I understand that a late charge is computed on account balances which remain unpaid 60 days after the first billing at a **PERIODIC RATE OF 1.5% PER MONTH**. This is applied to the entire balance due after deducting current payment and/or credits appearing on my statement. (Annual percentage rate is 18%)

I understand that if I pay my account with a check, and the check is returned unpaid by the bank because of insufficient funds, I promise to pay a service charge of twenty-five dollars (\$25.00) for the first check, and a service charge of thirty-five dollars (\$35.00) for every other check returned by the bank unpaid.

If I do not abide by Arthroscopic Surgery Associates payment policies, my account may be assigned to a collection agency. Arthroscopic Surgery Associates shall be entitled to reimbursement of attorney and/or court fees incurred to collect charges.

Signature of Patient / Financially Responsible Party

Date

NOTICE OF SIGNIFICANT BENEFICIAL INTEREST

California Business and Professions Code Section 654.2 requires your physician to notify you when your physician, or someone in his or her immediate family, has a "significant beneficial interest", as that term is defined under Section 654.2, in any organization to which your physician refers you for services.

We are providing this notice to inform you that your doctor does have a beneficial interest in Summit Surgical, and Fresno Surgical Hospital.

Please be advised that you may choose any organization for the purpose of obtaining the services ordered or requested by Dr. Robert M. Mochizuki.

Signature of Patient / Financially Responsible Party

Date