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Son X. Nguyen, M.D., FACS
Houman Saedi, M.D., FACS
Houman Solomon, M.S., M.D., FASMBS, FACS
Aileen M. Takahashi, M.D., FACS

Name_____Date_____
(Please print)

FINANCIAL POLICY

_____1. Initial — I understand that I am required to pay for all charges on the date services are rendered unless I am covered by a health plan, which the physician accepts, and I am being seen for a service I know to be covered by my policy.

_____2. Initial — I understand that the Association of South Bay Surgeons accepts MasterCard/ Visa/ American Express, personal checks, money orders, or cash. If the bank returns my check I will be charged a $25.00 Service fee, which will be due and payable within three (3) days along with the amount of the original check.

_____3. Initial — I understand that if I receive a statement in the mail, the amount stating "my responsibility" is due in 10 days.

_____4. Initial — If my account exceeds 60 days, I understand that I am in a **collection status**, and a **finance charge** equal to 1.5 percent per month will be added to my account. Accounts more than 90 days past due will be sent to an outside collections agency.

MEDICAL INSURANCE POLICY

_____1. Initial — I understand that ASBS bills my insurance as a service and that I am ultimately responsible for my account in full, even if I have medical insurance. Should there be a problem with my insurance company not paving in a timely manner, or for the correct amount, I agree to pay the doctor and settle my differences with my insurance company.

_____2. Initial — I will pay all co-pays, deductibles or co-insurance due by the date of service.

_____3. Initial — I hereby authorize payment to Association of South Bay Surgeons of the insurance benefits otherwise payable to me. I authorize that a photographic copy of this policy is as valid as the original.

_____4. Initial — I hereby authorize the disclosure of my medical information to my stated insurance for the purpose of obtaining payment for serviced rendered.

Signature: _____ Date: _____

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