

**By signing this form, the responsible party listed below hereby acknowledges and agrees to the following:**

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Rancho Paseo Medical Group professionals and their assistants, appointees, or consultants as is necessary in their judgment;
2. I am aware that the practices of medicine, surgery, and other health disciplines do not constitute exact sciences, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations by the Rancho Paseo Medical Group. If I do not fully understand a procedure or its risks, consequences, or alternate methods of treatment, I have the right to question the appropriate health-care professional;
3. I understand that the Rancho Paseo Medical Group shall not be responsible or liable for the loss of or damage to any personal property;
4. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment and records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received;
5. The responsible party agrees to pay any balance due after the insurance company processes the claim within fifteen (15) days of notice from our billing service regardless of the reason for the balance due (for example, deductible amounts, co-insurance, or denial of benefits by the insurance carrier);
6. The responsible party acknowledges that, if any balance due to the Rancho Paseo Medical Group is not paid in a timely manner, attorney's fees, collection-agency costs, and any related fees to the Rancho Paseo Medical Group will be added to the balance due;
7. The responsible party acknowledges that, in accordance with California law (see below), we are hereby disclosing that the patient may have X-rays and/or laboratory services performed at the Rancho Paseo Medical Group, that we have a financial interest in these services, and that the responsible party has the right to choose to have these tests done elsewhere if desired.

*California Business & Professional Code section 650.02(f) and 4051.2 and California Labor Code section 139.3 require a written disclosure of financial interest by a Medical Office which performs X-rays and/or Laboratory Services. Said disclosure must indicate the financial interests of the office as well as the patient's right to have the services performed elsewhere if the patient so desires.*

**I hereby certify that I have read this statement and have had an opportunity to review with the group personnel any questions that I may have regarding the same.**

\_\_\_\_\_  
Patient's name  
(Please print.)

\_\_\_\_\_  
Responsible Party's name  
(if different from Patient's name)  
(Please print.)

\_\_\_\_\_  
Patient's and/or Responsible Party's signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
date

If signed by someone other than the patient, please select your legal relationship to the patient:

- Parent    Guardian    Spouse    Representative    Financially Responsible Party