San Diego Surgical Specialists
7910 Frost Street, Suite 450, San Diego, CA 92123
Phone: (858) 565-0104 Fax: (858) 565-0194

Gary R. Bench, MD
George A. Mueller, MD
Larry H. Pollack, MD
Mohan Krishnamoorthy, MD
Shawn R. Bench, MD

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between San Diego Surgical Specialists (SDSS - the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients.

MEDICAL INSURANCE: We have contracts with many insurance companies and we will bill them as a service to you. You are financially responsible if your insurance declines to pay for any reason.

Any co-insurance, deductible, or co-payment related to surgery is due PRIOR to the surgery date. Because final patient responsibility isn't determined until after the claim has been submitted to the insurance company and an EOB (Explanation of Benefits) has been issued by the insurance company, the amount we collect will be considered a "deposit" towards the amount due. Any additional amount owing after the claim has been submitted to the insurance company will be due within 30 days of receiving a statement from our office.

The Patient or Responsible Party must:

- Inform the provider of the current address and phone number for the Patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that all information is current.
- Pay any required co-pay or co-insurance at the time of visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 service charge.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the Patient's Responsible Party understands that SDGVS has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient or Patient's Responsible Party understands that they are responsible for all costs of collection including but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party for minor patients. You signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)_____

Patient Signature_____Date_____

Responsible Party Name (Please print)_____

Responsible Party Signature _____Date_____