Rancho Paseo Medical Group. 264 N. Highland Springs Ave. 5A. Banning, CA 92220

FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with Federal Truth-in-Lending Act.

Rancho Paseo Medical Group shall charge a FINANCE CHARGE on any part of the "previous balance" at the periodic rate of 1¼% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any "previous balance" as shown on the periodic statement, which is paid 90 days from the first billing of the "previous balance" or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 90 days unpaid and then to that portion of the "previous balance" which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and then finally to credit.

You may pay your entire balance at any time.

Any credit balances of $5.00 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of Insurance. Rancho Paseo Medical Group cannot accept the responsibility for collecting your Insurance claims or negotiation of a settlement on a disputed claim. Notwithstanding Insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by Insurance benefits.

Rancho Paseo Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Paseo Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued to the group.

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

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT

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 result of treatments of examination by Rancho Paseo Medical Group.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Rancho Paseo Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.

5. 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, 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.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Patient or Guardian: _____ Relationship: _____

Signature of Witness: _____ Date: _____