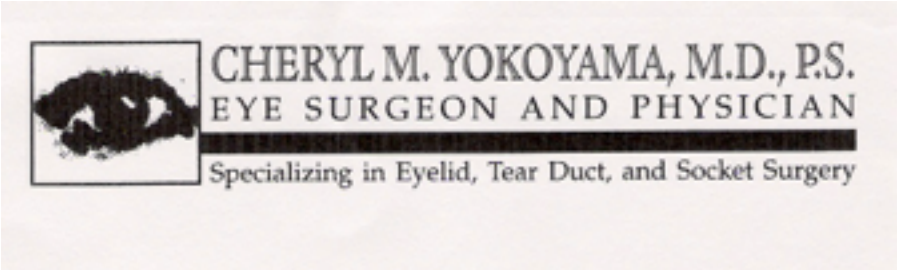


# FINANCIAL RESPONSIBILITY CONSENT FORM

I hereby authorize the release of any information to insurance carriers that is needed to process this claim for payment. I further authorize payment of any allowable insurance coverage payments to be issued directly to Dr. Yokoyama's office, which can then be applied to my account.

I understand that I am ultimately personally responsible for all charges incurred for services rendered to me by Dr. Yokoyama even if not covered by my insurance. I understand that payment for these services rendered are due at the time of service.

I understand that I am held ultimately responsible for all charges incurred for services rendered to me, regardless of any insurance coverage that I may have. I am also aware that if my coverage requires PCP authorization and / or a referral for payment that I am responsible to make sure these are obtained prior to my appointment. Furthermore, if my plan refuses reimbursement to Dr. Yokoyama for this reason, I understand that I will be held responsible for payment in full within 60 days of the service date.

I also agree to payment in full of any charges for rendered services within 60 days of the date of service regardless of any insurance coverage. I realize that I will be charged a standard 1.5% finance charge per month for any remaining balance after 60 days and that Dr. Yokoyama reserves the right to send my account to an outside collection agency if my account goes uncollected beyond 90 days from the date of service.

_____ _____

Patient/Responsible party signature Date

_____ _____

Staff Witness signature Date