



**FINANCIAL POLICY**

It is our policy to bill your insurance carrier as a courtesy to you. Any secondary insurance billing is the responsibility of the patient. If your insurance carrier does not remit payment within 60 (sixty) days, the balance will be due in full from you. Any payments subsequently made by your insurance carrier, in excess of the balance of your account, will promptly be refunded to you. If any insurance payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Santa Rosa Sports Medicine, INC. A late fee of \$5.00 will be added to your balance if payment is not received within 30 days of the statement date. An additional \$5.00 late fee will be added each 30 days thereafter until payment is received in full.

Be advised if you are a Workman’s Compensation patient, you may be held responsible for charges in the event your claim is denied.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Santa Rosa Sports Medicine, INC., I will be responsible for all costs of collecting monies owed: including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. I UNDERSTAND MY REponsibility FOR THE PAYMENT OF MY ACCOUNT.

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative of Santa Rosa Sports Medicine, Inc

\_\_\_\_\_  
Date

**CONSENT FOR CARE AND TREATMENT OF A MINOR**

I, the undersigned do hereby agree and give my consent for Santa Rosa Sports and Family Medicine Inc. to furnish any medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating their physical and mental condition.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

