



A MEMBER OF SAINTÉ FOUNDATION MEDICAL GROUP & PART OF SAINTÉ HEALTH FOUNDATION

## Patient Agreement of Financial Responsibility

Simonian Sports Medicine Clinic ("SSMC") is committed to providing quality care and service to all our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient, and sign and date below. Should you have any questions regarding the SSMC policies, please bring them to our attention before you sign this agreement.

\_\_\_\_\_ **Consent to Medical Services:** By signing this agreement, you consent to and authorize the performance of all treatment, surgeries, and medical services rendered by Simonian Sports Medicine Clinic and any other medical professionals at SSMC.

\_\_\_\_\_ **Insurance Information:** You are responsible for making sure we have all the current and accurate insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you and/or denial of coverage by your insurance company. We ask that you update and verify your insurance information in our file at each visit, as well as whenever there may be a change or update to your insurance coverage.

\_\_\_\_\_ **Agreement to Pay for Medical Services:** You understand and agree that you are personally and fully responsible for all charges for the services provided by SSMC, which include without limitation all medical and health-related services such as visits, consultations, routine examinations, testing, treatment and surgeries. You further understand and agree that it is your responsibility to know if your insurance has any deductible, co-payment requirement, co-insurance, out-of-network terms, limits, prior authorization requirements, or any other type of benefit limitation for the services you receive, and you agree to comply with all requirements of your insurance and agree to make payment in full to SSMC for any amount billed by SSMC that may not be covered or paid by your insurance.

\_\_\_\_\_ **Non-Covered Services:** We will do our best to confirm your insurance coverage before any medical services are provided to you, but it is ultimately your responsibility to know your benefits and to pay your bill from SSMC, including without limitation any co-payments, co-insurance, and deductibles. Our confirmation of insurance benefits and coverage is not a guarantee of payment from your insurance. Any service performed by SSMC that is not covered by your insurance is your sole responsibility to pay.

\_\_\_\_\_ **Referrals:** You understand and agree that it is your responsibility to know if your insurance requires a referral from your primary care physician (or requires some other authorization), and that it is up to you to obtain the referral or authorization. You further understand and agree that without this referral or authorization, your insurance may not pay for any services from SSMC and you will then be personally and fully responsible to pay SSMC for all services rendered.

\_\_\_\_\_ **Self-Pay:** If you do not have health insurance, are on an insurance plan we are not contracted with, or if we are unable to confirm your coverage at the time of service, we may collect an estimated payment from you before you are seen by a doctor. There may be additional charges depending on the services provided by SSMC, for which you may receive a bill that exceeds the estimated payment you make. You agree to be personally and fully responsible for all charges for the services provided by SSMC if you are not insured.

\_\_\_\_\_ **Returned Checks:** We charge a \$25.00 fee for any returned checks.

\_\_\_\_\_ **No Show Policy:** If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before the date of the appointment.

\_\_\_\_\_ **Minors:** For all services rendered to minor patients, the parent, guardian, and/or responsible party will be required to sign this agreement and agrees to be fully responsible for all payments due to SSMC for all medical services that are provided by SSMC.

\_\_\_\_\_ **Delinquent Accounts:** Your account may be sent to a collection agency if the balance is over 90 days old, and partial or no payment has been made towards the balance.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

\_\_\_\_\_ **Contact:** If you have any questions regarding your bill, please contact the SSMC billing office at (559) 228-4220.

I have read this Patient Agreement of Financial Responsibility and agree to be bound by its terms. I also understand that SSMC has the right to amend this agreement at any time.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

***Note: Simonian Sports Medicine Clinic is a part of  
Santé Foundation Medical Group (SFMG).  
All billing statements regarding charges incurred by any services  
provided by our physicians will come from and be processed by SFMG.***