



**Platelet-Rich Plasma (PRP) Financial Agreement and Consent**

Thank you for choosing the California Sinus Centers as your PRP health care provider. Our goal is to make the financial aspect of your treatment as stress-free as possible. To help you understand your financial responsibilities, we ask that you read and sign this agreement before any treatment starts.

**PLEASE READ THROUGH THE DOCUMENT, INITIAL WHERE INDICATED, AND SIGN**

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**PAYMENT**

Although PRP has shown promising results in certain medical applications, it is currently considered experimental and/or investigational by many insurance providers. As a result, PRP procedures are not covered by insurance benefits.

California Sinus Centers accepts most major credit cards as payment. Cash and checks are not accepted.

\_\_\_ Payment for all treatments are due at the time of the treatment and must be paid in full prior to the first treatment being rendered.

\_\_\_ All treatments are final sale; there are no refunds

\_\_\_ I understand that treatment and/or revisions of undesired results, unforeseen occurrences and/or complications have additional costs.

\_\_\_ The total amount due at the first scheduled treatment for the series of three treatments is \$4,500

**CANCELLATION AND NO-SHOW POLICY**

At the California Sinus Centers, we value every client’s time as much as our own. In order to provide each client with the highest quality experience, it is essential that you arrive on time.

\_\_\_ If for any reason I anticipate being late, I will call the office to inform of my late arrival so that necessary arrangements can be made.

\_\_\_ In the event that I need to cancel or reschedule, I will notify the office 24 business hours prior to my appointment.

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**ACKNOWLEDGEMENT**

By electing to proceed with PRP treatment, I acknowledge and understand that I am fully financially responsible for all charges related to the procedure, including any associated office visits, supplies, or additional services rendered. Payment is due according to the office’s financial policy.

I have had the opportunity to read this financial statement in its entirety and to ask questions regarding the details outlined above. Any questions I have had were answered to my satisfaction.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Representative Name

\_\_\_\_\_  
Patient or Patient Representative Signature

\_\_\_\_\_  
Date