**COLONIAL MEDCARE, P.C.**
**2801 BOULEVARD, SUITE B**
**COLONIAL HEIGHTS, VIRGINIA 23836**
**(804) 524-0524**

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## CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Colonial Medcare, P.C. to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ _____
Patient/Guardian Date

## BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to Colonial Medcare, P.C.. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records to secure payment.

_____ _____
Patient/Guardian Date

## FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, your recognized obligation is to promptly remit the same to Colonial Medcare, P.C.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised, if you claim worker's compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs associated with collecting monies owed, including court costs, collection agency fees and attorney's fees.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Center Representative Date