



RICHMOND BONE & JOINT CLINIC, P.A.

**CONSENT FOR CARE AND TREATMENT**

I, the undersigned do hereby agree and give my consent for Richmond Bone & Joint Clinic/Richmond Bone & Joint Surgical to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical condition.

**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 payers to Richmond Bone & Joint Clinic/Richmond Bone & Joint Surgical. 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/Responsible Party: \_\_\_\_\_

**FINANCIAL POLICY STATEMENT**

I have read and understand the Financial Policy of **Richmond Bone & Joint Clinic/Richmond Bone & Joint Surgical**. I 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 of collecting monies paid, including court costs, collection agency fees, and attorney fees.

**FINANCIAL POLICY STATEMENT**

I have read and understand the Patient Privacy Practices provided to me by **Richmond Bone & Joint Clinic/Richmond Bone & Joint Surgical**. I understand that my personal health information will be used in treatment, payment and operations; including those activities which are performed in order to improve the quality of care. I acknowledge my receipt of this information.

**I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT**

\_\_\_\_\_  
Print Patient's Name Here

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Representative/Witness

\_\_\_\_\_  
Date

**Richmond Bone & Joint Clinic/Richmond Bone & Joint Surgical**  
1517 Thompson Highway, Richmond, TX 77469 (281) 344-1715 (281) 344-1716