Family Doctor Clinic
804 South Acadia
Thibodaux, LA 70301
(985) 446-2680

Account # ____________________ Chart # ____________________

Resp. Party # ____________________ DR ____________ LOC ____________

I. PATIENT INFORMATION

Patient ______________________________ (Last / First / Middle)   Title: Mr./Mrs./Other: __________ Suffix: Jr./Sr./Other __________

Mailing Address ______________________________   ______________ City ______ State ______ Zip

Hm.Ph. __________ Wk.Ph. __________ Ext. ______   Date of Birth ______________ Sex: M or F

Social Security # ______________________________   Marital Status: Married Single Widowed Divorced (circle one)

Employer ______________________________   Student: Full Part-time (circle one)

Referred by ______________________________   Employment Status: (circle one) Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

Date of Injury ______________________________   Is the injury work related? ______________

ALLERGIC TO ______________________________   Cell Phone No. ______________

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Responsible Party ______________________________ (Last / First / Middle)   Title: Mr./Mrs./Other __________ Suffix: Jr./Sr./Other __________

Mailing Address ______________________________   ______________ City ______ State ______ Zip

Hm.Ph. __________ Wk.Ph __________ Ext. ______   Date of Birth ______________ Sex: M or F

Social Security #: ______________________________   Employment Status: (circle one) Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

Employer ______________________________

III. INSURANCE INFORMATION

PRIMARY

Insurance Company ______________________________

Address ______________________________

______________ City ______ State ______ Zip

Patient's Relationship to Insured: Self Child Mate Other

Group # __________ Policy # __________

CoPay: Primary Care __________ Specialist __________

Insured's Name ______________________________ (Last / First / Middle)

SECONDARY/SUPPLEMENTAL

Insurance Company ______________________________

Address ______________________________

______________ City ______ State ______ Zip

Patient's Relationship to Insured: Self Child Mate Other

Group # __________ Policy # __________

CoPay: Primary Care __________ Specialist __________

Insured's Name ______________________________ (Last / First / Middle)

IV. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address ______________________________

______________ City ______ State ______ Zip

Hm.Ph. __________ Wk.Ph __________ Ext. ______

Date of Birth ______________ Sex M or F

Employer ______________ Status ______________

Address ______________________________

______________ City ______ State ______ Zip

Hm.Ph. __________ Wk.Ph __________ Ext. ______

Date of Birth ______________ Sex M or F

Employer ______________ Status ______________

I hereby authorize the above listed insurance companies to pay directly to Family Doctor Clinic benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be paid. I authorize Family Doctor Clinic and to release information to the insurance company for my claims to be paid. Please attach copy of insurance card.

______________________________ Signature   ______________________________ Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FINANCIAL POLICIES

COMMERCIAL HEALTH INSURANCE

As a courtesy to me, the physicians at The Family Doctor Clinic will file claims for healthcare services provided on my behalf directly to my health insurance carrier. I hereby assign directly to my physician(s) and any and all health insurance benefits to which I am entitled and which are payable to me for any such services rendered.

I understand that independent of my health insurance policy, I assume personal financial responsibility for all charges incurred for services provided by my physician(s) on my behalf.

MEDICARE

The physicians at The Family Doctor Clinic accept Medicare assignment on Medcare approved charges. I understand that I am personally financially responsible for any required deductible(s) and/or co-payment(s).

As a courtesy to me, the physicians at The Family Doctor Clinic will file claims for healthcare services provided on my behalf directly to my Medicare Supplemental health insurance carrier. I hereby assign directly to my physician(s) any and all such supplemental health insurance benefits to which I am entitled and which are payable to me for any such services rendered.

NO INSURANCE

If there is no health insurance or other such coverage for the charges incurred on this account, I agree to pay the full balance of such charges at the time of services or in accordance with payment terms agreed upon by The Family Doctor Clinic.

IF YOU DO NOT HAVE INSURANCE, NOTIFY RECEPTIONIST PRIOR TO SEEING PHYSICIAN

RELEASE OF INFORMATION

I authorize my physician(s) to release any and all medical information, including but not limited to a photocopy of my medical records, which may be requested by my insurance company and/or which is necessary to process my insurance claim(s) or to secure the payment of health insurance benefits.

Further, I authorize the use of my signature below on all insurance submissions made by my physician(s) for healthcare services provided on my behalf.

I authorize The Family Doctor Clinic (or their designated staff under the physician's direction) to verbally give my test results to the people listed below from this day forward until otherwise notified:

1.____________________ 3.____________________

2.____________________ 4.____________________

I have read and understand the above and I agree to abide by these financial policies of The Family Doctor Clinic. I understand and agree that such policies may be changed from time to time in the sole discretion of The Family Doctor Clinic.

______________________________ ________________

Signature of Patient or Responsible Party *Date*