DOCTOR YOU ARE HERE TO SEE: _____

UROLOGY CENTER OF SOUTHWEST LOUISIANA

234 SOUTH RYAN STREET
LAKE CHARLES, LOUISIANA 70601

1327 STELLY LANE, SUITE 2
SULPHUR LOUISIANA 70663

PATIENT

FULL NAME _____

ADDRESS: _____
Street City State ZIP+4 Physical Address

HOME PHONE _____ WORK PHONE _____ CELLULAR PHONE _____

MPLOYER _____ **SOCIAL SECURITY #** _____

DATE OF BIRTH _____ SEX _____ AGE _____ **DRIVERS LIC #** _____ ST _____

REFERRED BY _____ MARITAL STATUS: S M D W

RELATIONSHIP TO RESPONSIBLE PARTY _____

IS THIS VISIT DUE TO: A WORK-RELATED INJURY OR ILLNESS? YES ❑ NO ❑ -- IS THIS FOR A LIABILITY CASE? YES ❑ NO ❑

SPOUSE

SPOUSE'S FULL NAME _____ **DATE OF BIRTH** _____

SS # _____ EMPLOYER _____ EMPLOYER'S PHONE # _____

RESPONSIBLE PARTY

RESPONSIBLE PARTY (If different from above)

FULL NAME _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX _____ **DRIVERS LIC #** _____ ST _____

ADDRESS _____
Street City State ZIP+4

(Physical address, No P.O. Boxes) _____

HOME PHONE _____ EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____

INSURANCE

AS A COURTESY TO OUR PATIENTS, WE WILL FILE YOUR CLAIM WITH YOUR PRIMARY AND SECONDARY CARRIERS FROM INFORMATION YOU PROVIDE BELOW. AFTER INSURANCE PAYMENTS ARE RECEIVED, YOU WILL RECEIVE A STATEMENT FOR THE PORTION OF THE BILL YOU ARE RESPONSIBLE FOR PAYING.

PRIMARY INSURANCE COVERAGE:

INSURANCE CO. NAME _____ EFFECTIVE DATE _____ POLICY HOLDER _____

POLICY HOLDER'S D.O.B. _____ POLICY HOLDER'S SEX _____ POLICY HOLDER'S S.S. # _____

POLICY # _____ GROUP # _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COVERAGE:

INSURANCE CO. NAME _____ EFFECTIVE DATE _____ POLICY HOLDER _____

POLICY HOLDER'S D.O.B. _____ POLICY HOLDER'S SEX _____ POLICY HOLDER'S S.S. # _____

POLICY # _____ GROUP # _____ RELATIONSHIP TO PATIENT _____

PERSONS TO CONTACT IN CASE OF EMERGENCY OTHER THAN YOUR HOME	NAME _____	NAME _____
	PHONE# (_____) _____	PHONE # (_____) _____

AUTHORIZATION:

The undersigned patient or authorized individual, acting on behalf of the patient, understands and agrees as follows:

1. UROLOGY CENTER OF SOUTHWEST LOUISIANA, reserves the right to assign any physician of this group to perform and administer all care and treatment of the patient.
2. UROLOGY CENTER OF SOUTHWEST LOUISIANA, is granted permission to release to the insurance carrier, employer, their representatives or referring physicians any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.
3. Patient shall pay to UROLOGY CENTER OF SOUTHWEST LOUISIANA, such sums as are now or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if any there be, does not make payment, or only partial payment, this obligation to pay shall be binding personally upon patient, or responsible party.
4. I hereby authorize my insurance company to pay directly to UROLOGY CENTER OF SOUTHWEST LOUISIANA, the surgical and/or medical benefits otherwise payable to me, for myself or any member of my family, for services rendered on the report, but not to exceed the charges to such services. I understand that I am personally financially responsible for these charges, whether covered by insurance or otherwise.
5. The undersigned patient, parent or guardian, hereby agrees that if this account is referred to an attorney or any collection agency for collection, that the undersigned will pay all costs of collection, including reasonable attorney's fees, which are hereby stipulated to be one-third of the amount due or a minimum of $500.00, whichever is greater. If the account is not paid within 90 days from date of service performed, the undersigned agrees to pay interest on the balance due at the rate of 1 1/2% per month (18% annual percentage rate) until the account is paid in full. It is expressly understood and agreed that exclusive venue and jurisdiction for collection of unpaid accounts shall be Lake Charles City Court, Lake Charles, Louisiana.
6. It is expressly understood and agreed that any disputes, grievances or complaints arising our of any medical services or treatment rendered to the undersigned patient shall be pursuant to the Louisiana Health Provider Act, LA-R.S. 40:1299.41, et seq., and that the exclusive venue and jurisdiction for any matter or action shall be the Fourteenth Judicial District Court for Calcasieu Parish, Louisiana.

SIGNATURE _____ DATE _____ ACCT # _____

RELATIONSHIP TO PATIENT _____