

LAGRAIZE MEDICAL, LLC

Appt Date _____ Acct# _____
Time _____

Name _____ Jr/Sr _____ Sex _____ M _____ F
Prefer to be Called _____ Age _____ Birthdate _____
Spouse _____ HomePhone _____ Work _____
Cell# _____ Pager# _____ email _____
Address _____

Street # Street Name Apt #
City State Zip

Referred By _____
Social Security _____
Employer _____ Phone _____
Contact Person in case of emergency _____
Phone # _____

BILLING INFORMATION IF DIFFERENT FROM ABOVE:

Parents or Guardian Information If Patient is Minor or other legal Guardian:

Name Street # City State Zip
Home Phone # Work #
Social Security# Birthdate
Spouse Birthdate SS#

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office.

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of Cash, Check, Mastercard or Visa. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Please check the rules of your insurance coverage.

Additionally, I understand that I am responsible for all fees including Legal or other costs incurred in the collection of the account should it become **DELINQUENT**.

Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when assigned claim is filed. I have received the notice of privacy practices.

PATIENT/GUARDIAN

SIGNATURE _____ DATE _____

PRIMARY INSURANCE

Policy # _____ Group# _____
Insured/s Name _____ Relationship to the Patient _____
Insured's SS# or Policy ID# _____
Insurance Company Name _____
Insurance Company Address _____

SECONDARY INSURANCE

Policy # _____ Group# _____
Insured's Name _____ Relationship to the Patient _____
Insured's SS# or Policy ID# _____
Insurance CompanyName _____
Insurance Company Address _____

FOR MEDICARE PATIENTS ONLY

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$110.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____ Date _____
Signature as it appears on Medicare Card

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____