LOUISIANA CARDIOLOGY ASSOCIATES

PATIENT INFORMATION

______________________ ☐ Male ☐ Female ______________________
Full Name | Maiden Name

______________________ ______________ ☐ Single ☐ Married ☐ Divorced ______________
SSN | DOB | Name of Spouse

Physical Address: Street ______ City ______ State ______ Zip Code ______

Mailing Address: Street ______ City ______ State ______ Zip Code ______

Home Telephone Number ______ Secondary Phone Number ______ Cellular Phone Number ______

Employer ______ Occupation ______ Work Phone Number ______

SECONDARY OR EMERGENCY CONTACTS:

Name ______ Phone Number ______ Relationship to Patient ______

Name (*NOT living with patient*) ______ Phone Number ______ Relationship to Patient ______

Did a physician refer you to our clinic? ☐ Yes ☐ No ______________________
Name and address of referring physician

Name of your family physician: ______________________

GUARANTOR INFORMATION IF THE PATIENT IS A MINOR:

Name and address of guarantor: ______________________

Mailing Address: ______________________

Relationship of guarantor to patient: ______________________

Guarantor Date of Birth: ______________ SS#: ______________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced Phone (Home): ______________ (Secondary or Cell#): ______________

GUARANTOR'S EMPLOYER: ______________________ **Phone**: ______________

INSURANCE INFORMATION

☐ Medicare: ______________ ☐ Medicaid: ______________
Medicaid Number

☐ Worker's Compensation – For Verification, Call: ______________________

☐ Private Insurance: ______________ ______________
Name of Company | Policy Number

Secondary ______________ ☐ Male ☐ Female ______________ ______________
Name of Insured | Date of Birth | SS#

Private Insurance: ______________ ______________
Name of Company | Policy Number

______________ ☐ Male ☐ Female ______________ ______________
Name of Insured | Date of Birth | SS#

I understand that I am responsible for the payment of this account, subject to the terms noted below. I also agree to present my insurance card at each visit to Louisiana Cardiology Associates (LCA) in order to allow for verification of insurance carrier information on file.

PRIVATE INSURANCE – As a courtesy to me, LCA will file my claims based on the information provided. Should this information prove incorrect, I am responsible to pay the balance in full. I agree that my insurance benefits may be paid directly to LCA and payment of all deductibles and co-payments are required at the time of service. Any allowable amount not paid by my insurance carrier must be paid within 30 days of receipt of a statement.

MEDICARE – LCA accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s) or co-payment(s). If there is a Medicare supplement insurance policy, LCA will file my claims as a courtesy to me, and the benefits may be sent directly to LCA.

MEDICAID – I understand that LCA accepts Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or denies these benefits, I agree to be responsible for payment of the account.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges at the time of service.

RELEASE OF INFORMATION – Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), LCA has my permission to furnish same.

If I fail to make any payment due as outlined above or as agreed upon, LCA may turn this account over to a collection agency and/or attorney for handling. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney.

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Patient/Responsible Party

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Date