

Account # \_\_\_\_\_ **Drs. Louapre, Kokemor, Sarrat & Braedt, LLC** F/C \_\_\_\_\_

Resp. Party # \_\_\_\_\_ DR \_\_\_\_\_ LOC \_\_\_\_\_

**I PATIENT INFORMATION**

Patient \_\_\_\_\_ Title: Mr./Mrs./Other: \_\_\_\_\_ Suffix: Jr./Sr./Other: \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_ City State Zip

Hm. Ph. \_\_\_\_\_ Wk. Ph. \_\_\_\_\_ Ext. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Cell Phone: \_\_\_\_\_ 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: Full-time Self Employed  
(circle one) Part-time Not Employed Unknown  
Retired Military Active

Date of Injury \_\_\_\_\_ Is the injury work related? \_\_\_\_\_

**II RESPONSIBLE PARTY INFORMATION**

*SEND STATEMENT TO*

Patient \_\_\_\_\_ Title: Mr./Mrs./Other: \_\_\_\_\_ Suffix: Jr./Sr./Other: \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_ City State Zip

Hm. Ph. \_\_\_\_\_ Wk. Ph. \_\_\_\_\_ Ext. \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M or F

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

Employer \_\_\_\_\_

**III MISCELLANEOUS INFORMATION**

*NAME OF NEAREST RELATIVE NOT LIVING WITH YOU*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**NOTIFY IN CASE OF EMERGENCY**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Person responsible for bill if other than patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**IV INSURED INFORMATION**

*INSURANCE POLICY HOLDER*

Name: \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City State Zip City State Zip

Hm. Ph. \_\_\_\_\_ Wk. Ph. \_\_\_\_\_ Ext. \_\_\_\_\_ Hm. Ph. \_\_\_\_\_ Wk. Ph. \_\_\_\_\_ Ext. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F Date of Birth: \_\_\_\_\_ Sex: M or F

Employer: \_\_\_\_\_ Status \_\_\_\_\_ Employer: \_\_\_\_\_ Status \_\_\_\_\_

Social Security #: \_\_\_\_\_

I hereby authorize the above listed insurance companies to pay directly to **Drs. Louapre, Kokemor, Sarrat & Braedt, LLC**, benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be authorized by my insurance and acknowledge that any outstanding amounts due from me greater than 30 days will be assessed a finance charge of 1½% per month. I hereby authorize **Drs. Louapre, Kokemor, Sarrat & Braedt, LLC**, to release information to the insurance company for my claims to be paid. Attached is a copy of my insurance card.

Signature

Date

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

### GENERAL CONSENT TO TREATMENT

I agree and consent to a physical examination. I understand that additional diagnostic procedures and treatment may be recommended by the physician and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the result of any procedures or medical treatment.

### RELEASE OF INFORMATION

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid, and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party payor, when such information is requested for payment, workers' compensation, utilization review or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing.

### FOR PATIENTS WITH INSURANCE

We bill most insurance carriers for you if benefits can be verified prior to your appointment. We will also bill most secondary companies for you provided that you have presented all insurance information. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. IF AN INSURANCE CARRIER HAS NOT PAID WITHIN 60 DAYS OF BILLING, PROFESSIONAL FEES ARE DUE AND PAYABLE IN FULL FROM YOU.

### ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE

I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.

I authorize assignment to the physician who has provided services to the patient the insured's right to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (La. R.S. 22:657).

### ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES

I understand that the physician will, as a courtesy, file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payor unless there is a specific written agreement between the physician and the patient or between the physician and the payor. Any account greater than 60 days old will be considered delinquent and subject to interest charges @ 1.5% per month. I will also be responsible for all attorney's fees, court costs, or agency fees, should account be referred to an outside agency for collection.

### MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Louapre, Kokemor & Sarrat, LLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian/Legally Authorized Representative