SOUTHERN VASCULAR CLINIC

5000 Ambassador Caffery Pkwy
Building 1, Suite 100
Lafayette, LA 70508
337-534-4444

Patient Information Sheet

Last Name _____ First Name_____ Middle Name_____

Gender _____Male_____Female DOB _____ Social Security #_____-_____-_____

Address _____ Address (additional) _____

Zip Code _____ City_____ State_____ Driver's License #_____

Home Phone _____ Mobile Phone_____ Work Phone _____

Patient Email _____

Language _____ Race_____ Ethnicity_____ Marital Status_____

Emergency Information

Emergency Contact_____ Relationship to Patient _____

Home Phone_____ Mobile Phone _____

Billing Information

Primary Insurance _____ Member ID/Number_____

Group Number_____ Patients relationship to guarantor _____

Last Name _____ First Name_____ DOB_____

Home Phone _____ Mobile Phone_____ Social Security #_____-_____-_____

Secondary Insurance _____ Member ID/Number_____

Group Number_____ Patients relationship to guarantor _____

Last Name _____ First Name_____ DOB_____

Home Phone _____ Mobile Phone_____ Social Security #_____-_____-_____

Authorization to Release Medical Information

Name _____Relationship _____ Telephone #_____

Name _____ Relationship _____ *Telephone #*_____

Patient/Guardian Signature _____ **Date**_____

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Important Agreements

please read carefully sign and date

Financial Agreement

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 minor procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified, and you will be asked to pay any unmet deductible, non-covered services and co-payments. Please check the rules of your insurance company.
Additionally, I understand that if my account becomes DELIQUENT after 90 days, I will be Discharged from the practice and will be responsible for all fees including Legal or other costs incurred in the collection of the account.

Patient/Guardian Signature _____ **Date**_____

For Medicare Patients Only

Southern Vascular is a participating provider of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental insurance carriers, however if the secondary does not pay within 60 days, the patient will be balanced billed.
I authorize any holder of medical or other information about me to release 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.

Patient/Guardian Signature _____ **Date**_____

If you have a supplemental policy and it's a MEDIGAP policy to which you Medicare Carrier automatically "crosses over", Southern Vascular is 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.

Patient/Guardian Signature _____ **Date**_____

Authorization to Release Medical Information and Medical Treatment

Southern Vascular is authorized to release to or request from any insurance companies having coverage on me, the induvial(s) whom the patient has given authority to receive all information pertaining to your care or referring physician or institution any of my medical records pertaining to any injury or illness. A copy of this authorization shall be considered valid and effective; I also, hereby, authorize Southern Vascular to treat me for any illness related to my health and well-being, either at this office or in the hospital.

Patient/Guardian Signature _____ **Date**_____