

Children's Clinic of SWLA Patient Registration

Guarantor Acct No. _____
Responsible Party: _____
(Who is responsible for medical services)
Father's Name _____
Mother's Name _____
Other _____
Relationship _____

Responsible Person's Address:

Street _____
City _____
State _____ Zip _____
Phone _____

Father's Information:

SS# _____
Date of Birth _____
Driver's Lic # _____
Home No. _____
Cell No. _____
Employer Name _____
Employer No. _____
Ins. Carrier _____
Ins. Address _____
Ins. Phone No. _____
Group # _____ Policy # _____

Mother's Information:

SS# _____
Date of Birth _____
Driver's Lic # _____
Home No. _____
Cell No. _____
Employer Name _____
Employer No. _____
Ins. Carrier _____
Ins. Address _____
Ins. Phone No. _____
Group # _____ Policy # _____

Account Name _____
Patient Acct No. _____ Date _____

Child's Name _____
Date of Birth _____ Sex _____
Hosp. Where Born _____
Chart Number _____

Other Children in Family:

Name	Date of Birth	Chart #	Sex
------	---------------	---------	-----

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To Contact in Case of Emergency:

Relative _____
Street _____
City _____
Phone No. _____
Friend _____
Street _____
City _____
Phone No. _____

I HEREBY AUTHORIZE THE CHILDREN'S CLINIC OF SOUTHWEST LOUISIANA, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY CHILD/CHILDREN'S ILLNESS AND TREATMENT.

PRIVATE PAY PATIENTS:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE RESPONSIBLE PARTY AND NOT THE INSURANCE COMPANY. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

PATIENTS COVERED BY MANAGED CARE:

IF PAYMENT FOR SERVICES IS PAID BY A THIRD PARTY (HMO, INSURANCE COMPANY OR MANAGED CARE COMPANY), YOU WILL BE REQUIRED TO PRESENT THE FOLLOWING:

- ☐ 1. PROOF OF INSURANCE COVERAGE (CURRENT INSURANCE CARD).
- ☐ 2. PROOF OF DEDUCTIBLE PAYMENT (MOST RECENT E.O.B.).

FAILURE TO PRESENT SUCH INFORMATION MAY REQUIRE THAT YOU PAY FOR SERVICES IN FULL AT THE TIME OF YOUR VISIT. IN SUCH AN OCCURRENCE, YOU WILL BE PROVIDED WITH NECESSARY INFORMATION TO SUBMIT YOUR CLAIM TO YOUR THIRD PARTY PAYOR FOR REIMBURSEMENT OR WE WILL FILE FOR ANY MANAGED CARE CONTRACTS THAT WE HAVE ACCEPTED.

ALL PATIENTS OF THE CHILDREN'S CLINIC:

BY SIGNING BELOW, I UNDERSTAND THAT I AM RESPONSIBLE FOR APPLICABLE CO-PAYMENTS, DEDUCTIBLES AND FOR NON-COVERED SERVICES THAT ARE RECOMMENDED BY ANY CHILDREN'S CLINIC PHYSICIAN.

DATE _____ SIGNATURE _____