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 YOU R 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_____