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

Resp. Party # ______________ DR ______________ LOC ______

I. PATIENT INFORMATION

Patient ______________________ (Last / First / Middle)

Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ______

Mailing Address ______________________

______________ City ______ State ______ Zip

Hm. Ph. __________ Wk. Ph. __________ Ext. ____

Date of Birth ______________

Cell Phone ______________________

Sex: M or F Race: ______________

Email ______________________

Marital Status: Married Single Widowed Divorced (circle one)

Social Security # ______________________

Student: Full Part-time (circle one)

Employer ______________________

Employment Status: (circle one) Full-time Part-time Retired Self Employed Not Employed Military Active Unknown

Referred by ______________________

Date of Injury ______________________

Is the injury work related? ______________

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Patient ______________________ (Last / First / Middle)

Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ______

Mailing Address ______________________

______________ City ______ State ______ Zip

Hm. Ph. __________ Wk. Ph. __________ Ext. ____

Date of Birth ______________ Sex: M or F

Social Security # ______________________

Employment Status: (circle one) Full-time Part-time Retired Self Employed Not Employed Military Active Unknown

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 ______________________

IV. INSURED INFORMATION

INSURANCE POLICY HOLDER

Name ______________________

Address ______________________

______________ City ______ State ______ Zip

Hm. Ph. __________ Wk. Ph. __________ Ext. ____

Date of Birth ______________ Sex: M or F

Employer ______________ Status ______

Social Security # ______________________

Address ______________________

______________ City ______ State ______ Zip

Hm. Ph. __________ Wk. Ph. __________ Ext. ____

Date of Birth ______________ Sex: M or F

Employer ______________ Status ______

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 & Braedt, 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