



Lake Charles Memorial Health System

DBA Memorial Medical Group

PATIENT INFORMATION (PLEASE PRINT)									
Last Name (Jr, Sr, etc.)			First Name			Middle Initial	Social Sec #		
Date of Birth		Home Phone No. ()		Work Phone No. ()		Cell Phone No. ()			
Address				City		State	Zip Code		
Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female			Gender Identity			Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Email			Employer			Primary Care Physician			
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino			Race (mark all that apply): <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other			
RESPONSIBLE PARTY INFORMATION									
Person Responsible for Account (if different)				Home Phone No. ()		Cell Phone No. ()			
Address				City		State	Zip Code	Sex M F	
Date of Birth	Social Sec #	Employer			Email				
PRIMARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)									
Insurance Co.			Policy No.				Group No.		
Policy Holder Name			Policy Holder Address (if different from patient)						
Policy Holder DOB			Policy Holder SS#			Relationship to Patient		Effective Date	
SECONDARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)									
Insurance Co.			Policy No.				Group No.		
Policy Holder Name			Policy Holder Address (if different from patient)						
Policy Holder DOB			Policy Holder SS#			Relationship to Patient		Effective Date	
WORKER'S COMP INFORMATION (IF APPLICABLE)									
Worker's Compensation Company				Date of Injury		Verification Call Phone No.			
EMERGENCY CONTACT INFORMATION									
Name			Phone No. ()		Relationship to Patient				
Name (Not living in same household)			Phone No. ()		Relationship to Patient				
ADVANCED CARE PLAN (65 or older, do you have one of the following?)									
Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No			Healthcare Proxy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Healthcare Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes to any of the above, who is your Surrogate Decision Maker?									
Name:					Phone No. ()				

I understand that I am responsible for supplying Memorial Medical Group, Inc. with my current insurance coverage, including presenting my insurance cards, and to inform Memorial Medical Group, Inc. of any changes to my insurance coverage. Failure to comply with the above will change my status to a self-pay account. I understand I will receive services performed through the Lake Charles Memorial Health System. In the event of any overpayment or credit to any of my accounts for any hospital, clinic, and/or physician services within the Lake Charles Memorial Health System, I do hereby authorize and consent to the transfer and application by the Lake Charles Memorial Health System of said overpayment or credit to any of my accounts with outstanding balances or sums due, if any, which accounts may be within the Lake Charles Memorial Health System. I understand that I am primarily responsible for the payment of this account, subject to the terms noted below:

PRIVATE INSURANCE – As a courtesy to me, Memorial Medical Group, Inc. may file my claims with my insurance carrier. I agree that my insurance benefits may be paid directly to Memorial Medical Group, Inc. If my insurance plan is in network with Memorial Medical Group, Inc., I agree to be responsible for the deductible, any patient portion as determined by my insurance plan, as well as, any services that are deemed not covered under my insurance policy. If my insurance plan is out of network, I agree to be responsible to Memorial Medical Group, Inc. for the full balance of Memorial Medical Group, Inc.’s charges that are not paid by my private insurance carrier, including any deductible and/or copayment.

MEDICARE – Memorial Medical Group, Inc. accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s), coinsurance(s) or copayment(s). If there is a Medicare supplement insurance policy, Memorial Medical Group, Inc. will file my claims as a courtesy to me, and the benefits may be sent directly to Memorial Medical Group, Inc. If there is no supplemental policy, I am responsible for the payment of the balance of the assignment (Medicare 20% coinsurance).

MEDICAID – I understand that some providers in Memorial Medical Group, Inc. accept Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or my visits are exhausted, I agree to be responsible for payment of the account.

WORKERS’ COMPENSATION – I agree to allow Memorial Medical Group, Inc. to verify my Workers’ Compensation coverage with my employer or my employer’s insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any such information so requested will also be provided to the patient. I agree to be responsible for payment of all charges which are not paid by my employer or its Workers’ Compensation insurance carrier.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges in accordance with payment terms as agreed upon by Memorial Medical Group, Inc.

RELEASE OF INFORMATION – Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), Memorial Medical Group, Inc. has my permission to furnish same. Unless otherwise noted by me, I also give Memorial Medical Group, Inc. permission to furnish medical information and copies of my medical records to my referring and/or family physician.

If I fail to make any payment due as outlined above or as agreed upon, Memorial Medical Group, Inc. may turn this account over to a collection agency and/or attorney for handling. If this occurs, I may be subject to dismissal from Memorial Medical Group, Inc. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney.

Patient/Responsible Party (Signature)

Date

CONSENT FOR TREATMENT - I, the undersigned, do hereby authorize Memorial Medical Group, Inc. to provide medical care as deemed necessary in the judgment of the provider. This treatment may include, but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and intravenous medications or other therapeutic solutions, and minor surgical procedures.

Signature

Date