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4520 Wichers Dr. Suite 205
Marrero, LA 70072

Patient Information

Name of Patient: _____ Date of Birth: _____

Address: _____

Social Security Number: _____ Telephone: _____

Gender: Male Female Ethnicity: Hispanic Non-Hispanic Refuse to Report

Race: American Indian Asian African American Pacific Islander White Refuse to Report

Preferred Language: English French German Japanese Mandarin Russian Spanish

Policy Holder Information

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ Employer: _____

Social Security Number: _____ Telephone: _____

Primary Insurance Information

Primary Insurance: _____

Group Number: _____ Policy/I.D. No.: _____

Secondary Insurance Information

Secondary Insurance: _____

Group Number: _____ Policy/I.D. No.: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

Signed: _____ (Patient) Date: _____

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Southern Pain Relief for any services furnished me by its physician(s) and /or practitioners. 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. I permit a copy of this authorization to be used in place of the original.

Signed: _____ (Patient) Date: _____