BAYOU SURGICAL SPECIALISTS

Frederick Rau MD | David Rau MD | Eric Rau MD | Donald Schwab Jr MD

PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ Marital Status: Single Married Separated Divorced Widowed

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell #: _____ Work #:_____

Employer: _____ Occupation: _____

Email Address: _____ Referred by:_____

Family Physician: _____ Cardiologist:_____

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Guarantor Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #:_____ Relation to Patient: Spouse Parent Other(_____)

Home Phone: _____ Cell #: _____ Work #:_____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance(s):_____

INSURANCE POLICYHOLDER'S INFORMATION (IF NOT THE PATIENT)

Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ Relation to Patient: Spouse Parent Other(_____)

PATIENT BILLING NOTICE & RELEASE OF INFORMATION

- I assign benefits and authorize payment from my insurance plan (Medicare/Medicaid/Other) directly to Bayou Surgical Specialists for any claim filed on my behalf. I authorize the release of medical records and/or information to my insurance company to assist with payment for services rendered. I authorize the release of medical records to and from Bayou Surgical Specialists and other medical providers when necessary for my treatment or my care.

- I accept financial responsibility for all services that I receive and agree to pay for all services that are not paid by insurance benefits, for whatever reason – including, but not limited to deductibles, co-payments, co-insurance, and/or non-covered amounts.

- I understand that if I fail to make timely payment, I may be sent to a collection agency. I agree to pay collection and/or attorney fees if charged. I consent to receive communications regarding my account from any collectors until my account is settled. I will incur NSF fees for returned checks.

Patient Signature (or representative): _____ Date: _____

If Authorized Representative, please list relationship to patient:_____