The Cypress Clinic, LLC

622 Cypress St.
Sulphur, LA 70663
337-527-2491

Today's Date:

Patient's Name: | Date of Birth: | Sex:

Address: | SS Number: | Marital Status:

City: State: Zip: | Home Phone: | Drivers lic #:

Employer: | Employment Status: | Work Phone:

Cell:

Responsible Party: | Date of Birth: | Sex:

Address: | SS Number: | Marital Status:

City: State: Zip: | Home Phone: | Drivers lic #:

Relationship to Patient: | Cell:

Employer: | Employment Status: | Work Phone:

Health Insurance: (Provide insurance card to office staff)

Policy Number: | Group Number:

Name of Insured: | Relationship to Patient:

Insured Birth Date: | Insured Social Security #:

Secondary Health Insurance:

Policy Number:

Name of Insured:

Nearest Relative Not Living with You:

Address: Phone

Whom do we thank for referring you?

Authorization: The undersigned patient or authorized individual, acting on behalf of the patient, understands and agrees as follows:

1 **The Cypress Clinic** is granted permission to release to the insurance carrier, employer or their representatives or referring physicians any information in connection with any treatment rendered to patient or on the patient's behalf at any time such information is requested.

2 Patient shall pay to **The Cypress Clinic** such sums as are now or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if any there be, does not make payment, or only partial payment, this obligation to pay shall be binding personally upon the patient or responsible party.

3 I hereby authorize my insurance company to pay directly to **The Cypress Clinic** the surgical and/or medical benefits otherwise payable to me, for myself, any member of my family, for services rendered on the report, but not to exceed the charges for such services. I understand that I am personally financially responsible for these charges whether covered by insurance or otherwise.

4 The undersigned patient, parent or guardian, hereby agrees that if this account is referred to an attorney or any collection agency for collection, that the undersigned will pay all costs of collection, including reasonable attorney fees, which are hereby stipulated to be one-third of the amount due or a minimum of $500.00, whichever is greater. If the account is not paid within 90 days from date of service performed the undersigned agrees to pay interest on the balance due at the rate of 1 1/2% per month (18% annual percentage rate) until the account is paid in full.

5 It is expressly understood and agreed that any disputes, grievances or complaints arising out of any medical services or treatment rendered to the undersigned patient shall be persuant to the Louisiana Health Provider Act, LA R. S. 40:1299.41, et seq.

SIGNATURE: Date:

Relationship to patient: