

Dr. Kelly L. Cobb
605 Silverstone Rd, Ste 100,
Lafayette, LA 70508
Phone 337-266-9985 fax 337-266-4775

Patient Registration Information

PATIENT PERSONAL INFORMATION MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEX: MALE FEMALE

Name (First name, middle initial and last name): _____

Date of Birth: ____ / ____ / ____ Social Security #: _____ -- _____ -- _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt# _____ City: _____ State: _____ Zip: ____

PATIENT'S RESPONSIBLE PARTY INFORMATION Relationship to Patient: SELF SPOUSE CHILD OTHER _____

Name (full name): _____

Date of Birth: ____ / ____ / ____ Social Security #: _____ -- _____ -- _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Policy #: _____ Group# _____ Co-Pay: \$ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Insured: _____ Date of Birth: ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other

PATIENT'S REFERRAL INFORMATION (Who may we thank for this referral?)

Name: _____

Address: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Name: _____ Phone:(____) _____ - _____, Fax: (____) _____ - _____.

Address: _____ City: _____ State: ____ Zip _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

The medical practice of Dr. Kelly Cobb at Nouriche

605 Silverstone Rd, Suite 100

Lafayette, LA 70508

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ASSIGNMENTS OF BENEFITS/FINANCIAL AGREEMENT/OFFICE POLICY RE INSURANCE

I hereby authorize Kelly L Cobb MD to release medical records pertaining to my physical condition and treatment. I authorize the release of my medical records from other medical facilities to Dr. Cobb. My signature below is to be my authorization for release of medical records.

I authorize the release of information that may be necessary for claim reimbursement from insurance companies to whom claims may be submitted. I hereby give lifetime authorization for payment of insurance benefits to Dr. Kelly Cobb, APMC and any assisting physicians for services rendered.

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me, to my minor child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

We will file with your insurance company at the time of your visit. We will wait up to 60 days for payment. (La. Law says all claims must be paid within 30 days from receipt of claims.) We will submit a 2nd claim to insurance company if no payment received and will notify patient requesting their assistance in contacting their insurance carrier. We will wait an additional 30 days from this time. If no payment is received, the full balance of account will be due by the patient. Your cooperation is greatly appreciated.

This authorization and assignment may be revoked by me at any time by a written notice.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature_____