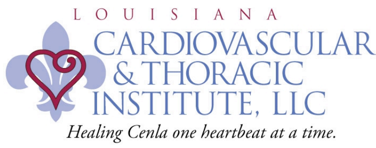

Gary P. Jones, MD, FACS
R. Chance DeWitt, MD, FACS

3311 Prescott Road, Suite 202
Alexandria, LA 71301
(318)442-0106 Fax: (318)448-8918
Tax ID # 61-1436519

Today's Date ____________________ **Doctor you are seeing today** ____________________

Name: ____________________ Sex: ______ Date of Birth: ____________ Race: __________

Address: ____________________ City: ____________ ST: ______ Zip: ____________

Home Phone: ______________ Wk Phone: ______________ Cell Phone ______________

E-mail: ______________ Patient's SSN: ______________ Marital Status: __________

Employer: ____________________ Referred by: ______________

Name of Spouse/Guardian: ____________________ Date of Birth: ____________ SSN: ______________

Name of relative/friend not residing with you: ________________________________

Relationship: ____________________ Phone: ______________

Additional contact name: ____________________ Relationship: ____________ Phone: ______________

PRIMARY INSURANCE INFORMATION – Please present your insurance card(s) to the receptionist.

Insurance Name: ________________________________

Policyholder's Place of Employment: ____________________ Address & Phone: ______________

SECONDARY INSURANCE INFORMATION – Please present your insurance card(s) to the receptionist.

Insurance Name: ________________________________

Policyholder's Place of Employment: Address & Phone:

OTHER INFORMATION

Is your visit related to an on-the-job injury? ______ Is your visit related to an auto accident? ______ If yes, date of injury ____________

Claim # ______________ Adjuster Name: ____________________ Phone: ____________

Attorney Name; ____________________ Phone: ______________

Address: ____________________ City: ______________ ST: ______ Zip: __________

FINANCIAL POLICY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Payment for service is due at the time services are rendered unless payment arrangements have been approved, or if you belong to an HMO. Any and all copayments due are to be paid prior to seeing the provider. We accept cash, checks, and credit cards.

We will be happy to assist you in processing your Insurance claim. Insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for the payment of this bill, except if you belong to an HMO, in which case you may be responsible only if you failed to secure prior authorization for services. Balances older than 90 days will be subject to interest charges at the rate of up to 1.5% per month.

I hereby authorize and direct my insurance company to make payments to my physicians, providers, and/or associates for services rendered, and I am financially responsible for non-covered services.

I also authorize the provider to release any information including but not limited to medical records required to process this claim. A photocopy of this assignment shall be considered as effective and valid as the original copy.

I have read an fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

PATIENT SIGNATURE ________________________________ ***DATE:*** ______________
PARENT/GUARDIAN (if patient is a minor)