DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

102 W 112th Street, Cut Off, LA 70345 | Phone: 985-632-5222 | Fax: 985-632-4222

PATIENT INFORMATION:

NAME (LAST, FIRST, MIDDLE):_____

SOCIAL SECURITY #: _____DOB: _____

BILLING ADDRESS: _____

CITY/STATE/ZIP: _____HOME PHONE #: _____

CELL PHONE #: _____EMAIL ADDRESS: _____

PHARMACY: _____

EMERGENCY CONTACT NAME: _____PH #: _____

EMPLOYER: _____WORK NUMBER: _____

ADDRESS: _____ CITY/STATE/ZIP:_____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE):

NAME (LAST, FIRST, MIDDLE): _____

SOCIAL SECURITY #: _____DOB: _____PHONE #: _____

BILLING ADDRESS: _____CITY/STATE/ZIP:_____

RELATIONSHIP TO PATIENT: _____

INSURANCE – PRIMARY – MUST PROVIDE COPY OF CARD:

_____

SECONDARY – IF APPLICABLE – MUST PROVIDE COPY OF CARD:

_____

I hereby authorize the release of information related to all treatment and care to Medicare and my insurance companies. I also authorize and request payment directly to Dr. Gary Birdsall Medical Clinic, LLC, for bills covering this period of treatment by all insurance carriers with which I have coverage, including Medicare. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me I further agree to pay all charges connected with this treatment not covered by insurance I may have an understand that insurance coverage does not release me from the obligation to begin payment within 30 days of treatment. Copies of this agreement shall be as valid as the original.

_____

Patient's Signature/Guardian Date