LOUISIANA CARDIOVASCULAR & LIMB SALVAGE CENTER, A.P.M.C.

Patient Name:_____Patient Date of Birth:_____

I understand that I am responsible for the payment of this account, subject to the terms noted below. I also agree to present my insurance card at each visit to Louisiana Cardiovascular and Limb Salvage Center, APMC (LCLSC) in order to allow for verification of insurance carrier information on file.

PRIVATE INSURANCE – As a courtesy to me, LCLSC will file my claims based on the information that I have provided. Should this information prove incorrect, I am responsible to pay the balance in full. I agree that my insurance benefits may be paid directly to LCLSC and payment of all deductibles and co-payments are required at the time of service. Any allowable amount not paid by my insurance carrier must be paid within 30 days of receipt of a statement, unless previous arrangements have been made with the Office Administrator (not the physician).

MEDICARE - LCLSC accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s) or co-payment(s). If there is a Medicare supplement insurance policy, LCLSC will file my claims as a courtesy to me, and the benefits may be sent directly to LCLSC.

MEDICAID – I understand that LCLSC accepts Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or denies these benefits, I agree to be responsible for payment of the account in full.

WORKER'S COMPENATION – I agree to allow LCLSC to verify my Worker's Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any requested information sent to my employer or the insurance carrier will also be provided to me. I agree to be responsible for payment of all charges which are not paid by my employer or its Worker's Compensation insurance carrier.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges at the time of service, unless previous arrangements have been made with the Office Administrator (not the physician).

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered to me by LCLSC. If I fail to make any payment due as outlined above or as agreed upon, LCLSC may turn this account over to a collection agency and/or attorney for handling. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney. I also acknowledge that it is my personal responsibility to make sure that all pre-certifications required by my insurance provider are completed according to my contract with them. I certify that the information on this form is true and correct to the best of my knowledge and that I will notify you of any changes in my status or the above information.

_____ _____

Patient/Responsible Party Signature Date