PATIENT #:_____

JOHN R. BUDDEN, M.D. APMC
2625 North Drive
Abbeville, LA 70510
johnrbuddenmd.com

PATIENT REGISTRATION (Please Print)

DATE: _____

PATIENT'S NAME: _____
(Last) (First) (Middle)

ADDRESS:_____**City/State**_____**Zip Code**_____

PATIENT'S BIRTHDATE:_____ **AGE:**_____ **SEX (check one):** **Male** ☐ **Female** ☐

HOME PHONE #:_____ **CELL PHONE #:**_____

WORK PHONE #:_____ **EMERGENCY #:** _____

MARITAL STATUS (check one): **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐

NAME OF HUSBAND/ WIFE:_____ **FAMILY DOCTOR:**_____

RESPONSIBLE PARTY NAME: _____
(Person Paying Bill or Insured Person) (Last) (First) (Middle)

ADDRESS:_____**City/State**_____**ZipCode**_____

HOME PHONE:_____**EMPLOYER #:**_____

EMPLOYER:_____**OCCUPATION:**_____

RELATIONSHIP TO INSURED PARTY: (check one): **Self** ☐ **Husband** ☐ **Wife** ☐ **Child** ☐ **Other** ☐

(Completion of ALL the above is necessary for our office records)

INSURANCE CO. NAME:_____

INSURANCE CO. ADDRESS:_____

City/State_____**Zip Code**_____

POLICY #:_____**GROUP #:**_____

SUBSCRIBER'S NAME:_____

SECOND INSURANCE CO. (if applicable):_____

SECOND INSURANCE CO. ADDRESS:_____

City/State_____**Zip Code**_____

POLICY #:_____ **GROUP#:**_____

TREATMENT AND FINANCIAL AGREEMENT: I hereby apply for treatment by John R. Budden, M.D. and his assistants. Such treatment may include: x-rays, injections and other office procedures as deemed necessary. I accept full responsibility for any charges incurred for services rendered to me.

INSURANCE ASSIGNMENT: This will authorize the filing of any insurance in force and the direct payment to John R. Budden, M.D. APMC, any amounts due from my claim under the above stated policy (policies). I understand that I am financially responsible for all charges not covered by my insurance policy. Release of any of my medical information, which may be necessary for the completion of insurance forms, is hereby authorized.

I understand that I will be responsible for all service charges, finance charges, court costs, collection agency fees and reasonable attorney's fees involved should this account be turned over for collection. I understand that I will be charged finance charges (18% APY), on any unpaid balance 90 days from the date of service. Failure to reschedule an appointment prior to your appointment time or failure to show up to your scheduled appointment will result in a $30.00 no show charge. This will be billed directly to you and will be your responsibility to pay prior to another visit being scheduled.

_____ _____

(Date) **(Witness)** **(Signed)** **(Insurance Subscriber if other than Spouse)**