Walk-In Clinic
ACADIAN HEALTH SERVICES, INC.

6011 Ambassador Caffery Parkway Youngsville, LA 70592
P.O. Box 51775 Lafayette, LA 70505
Phone 337-234-9925 • Fax 337-237-5211

Urgent Care: Patient Registration Form - Patient to Complete Shaded Area

Full payment is required at time of visit.

Office visit charges for established and new patients (patients not seen in past 3 years) are determined by the level of service provided.
Expanded office visits, patients with multiple concerns, are charged accordingly. Lab work, x-rays, procedures and medications are an additional charge.

If you are sent by an employer for a medical exam and/or treatment, verification of both employment and payment is required prior to medical treatment. In the event your employer does not pay for medical treatment, you understand you are solely responsible for all charges and do agree to pay any and all applicable charges.

Patient Information

Method of payment today will be:

Cash: ☐
Visa/Mastercard: ☐
Check: ☐

Referral Source:

Patient Name (Please Print):

Date of Birth: Age:

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ None/Child

Social Security #:

Address:

City:

Physical Address: ☐ Same if different from mailing address:

Home Phone: Race : White ☐ Black ☐ Asian ☐ Other

Cell Phone: Email Address:

Insurance Carrier: Policy Holders SS#: Policy Holders DOB:

Patient's Employer: Phone: Occupation:

Address:

City: State: Zip:

Notify in case of emergency: (Someone not living with you) Relation: Phone:

Spouse Information:

Name: Employer: Phone:

Minor Patient's Parent Guardian Information (if applicable)

Mother: Address: Phone:

Mother's Employer: Phone:

Father: Address Phone:

Father's Employer: Phone:

I authorize the release of any and all medical information concerning my (or my child's) health care necessary to process all claims through this clinic limited to all insurance claims. I understand and agree to any and all reasonable fees (not to exceed 30% of balance due) incurred as a result of my failure to pay the balance in full, causing the placement of this account with a collection agency and / or attorney.
I have read, understand and agree to these clinic policies.

Date: **Signature:**
(Patient/Guarantor)