



DR. SCOTT O'CONNOR

Fellow, American College of Foot & Ankle Surgery
 Diplomate, American Board of Podiatric Surgeons
 Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

 Patient's Last Name First Name MI Date of Birth Age Sex Social Security Number

 Street Address City State Zip

 Patient's Employer () - () - () -
 Home Phone Cell Phone Work Phone

Financially Responsible Party - Same as above? Yes ___ No ___

 Last Name First Name MI Date of Birth Age Sex Social Security Number

 Street Address City Home Phone -

 Patient's Employer Work Phone - Cell Phone -

Insurance Information – PLEASE PRESENT CARD FOR COPYING

Primary Insurance - _____ **Secondary Insurance** - _____

Policy Holder Name - _____ **D.O.B.** - _____

Emergency Contact : Name _____ Phone _____ Relationship _____

How did you find out about our office? Relative or Friend (Name) _____

Yellow Pages _____ (Yellow Book or Verizon) Sign _____ Insurance _____ Radio _____ Extreme Football _____

Doctor Referral (Name) _____ Website _____ Other (specify) _____

Treatment Authorization and Consent to Release Private Health Information

I hereby authorize treatment by Central Illinois Foot & Ankle Center. I understand that my healthcare information is private and that my insurance carrier will require this information in order to process claims for payment of services rendered by this medical provider. I authorize the release of pertinent information to my insurance carrier(s). I also authorize payments to be made directly to this medical provider by my insurance carrier(s).

X _____
 Signature of Responsible Party Date

Financial Agreement

I agree that I am responsible to pay co-pay amounts, deductibles and services not covered by my insurance company. I also understand that I will be responsible for any expense associated with the collection of a debt owed to the provider by me (i.e. attorney fees, court fees, collection agency). I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 33%-50% will be added to the total balance due. I also understand interest may be charged on all accounts, which are 30 days or more past due, at a rate of 1.5% per month, annual rate of 18%. I also understand that financial charges will be added to any account I have that is 90 days or more past due and here-by agree to pay such charges if levied.

X _____
 Signature of Responsible Party Date