



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 _____