MARK T. O'DONNELL, DPM
STEVEN A. CONNER, DPM

PATIENT REGISTRATION

Registration Date_____

Patient Name	Marital Status	Date of Birth	Sex	Age	Social Security Number

Patient Street Address	City, State, Zip Code	Home Phone No.
Name of Patient's Employer/School	Occupation	Cell/Work No.
Spouse/Guardian Name	Spouse/Guardian Date of Birth	Spouse/Guardian Phone No.
In Case of Emergency, Contact	Relationship	Phone No.
Family Doctor/Primary Care Doctor's Name		Phone No.
Pharmacy Name	Phone No.	How did you hear about our office?

INSURANCE INFORMATION

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth	ID#
Primary Insurance Company Address			Group #
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth	ID#
Secondary Insurance Company Address			Group #

CONSENT FOR PATIENTS UNDER 21 YEARS OF AGE

If Patient is Under 21 Years of Age
Responsible Party's Name and Address (if different from above)

Consents: Upon arrival in our office, you will be asked to sign three consents electronically. Below is the content of each consent.

Consent/Signature #1

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
And
PRIVACY NOTICE REGARDING CONTACTING YOU

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understand the notice. A copy is available in the office for your review.

Additionally, you will be asked the following questions about whether we may leave appointment or medical information via the following means. Please review the following and be able to answer when asked:

May we leave **appointment** information on your

- home phone answering machine? Yes No
- cell phone (if applicable)? Yes No
- office voice mail (if applicable)? Yes No
- with another person? Yes No

May we leave **medical** information on your

* home phone answering machine? Yes No
* cell phone (if applicable)? Yes No
* office voice mail (if applicable)? Yes No
* with another person? Yes No

Signature #2

PERMISSION TO TREAT AND BILL

I hereby authorize the physicians indicated above to perform the necessary examination in order to diagnose, perform routine treatment and to furnish all information to insurance carriers and other physicians involved in my care concerning this illness/incident. I hereby irrevocably assign to Mark T. O'Donnell, DPM, and Steven A. Conner, DPM, all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by insurance.

All patients are responsible for paying their co-pay at the time of their visit.

While we are happy to submit your claims to your insurance company, often there is additional financial responsibility for the patient. All patients are responsible for paying their balance in a timely manner after receiving their FIRST statement.

Our policy is that a maximum of two statements will be sent to the patient. If no payment is received from the second statement, a letter will be sent stating that payment is due immediately or the account will be turned over to collections. If no payment is received in a timely manner, the account will be turned over to collections.

Signature #3

PERMISSION TO RETREIVE PRESCIPTION INFORMATION

I give consent to Steven A. Conner, DPM, PC, to retrieve and use my medication history from SureScripts (a pharmacy clearinghouse that reconciles patient prescription medication history)

Additionally, you will be asked the following:

AUTHORIZATION TO RELEASE INFORMATION TO DESIGNATED OTHERS

Privacy rules restrict us from discussing your medical care or billing issues with others unless designated by you.

____ I do not wish to share my medical or billing information with anyone.

____ I authorize Steven A. Conner, DPM and Mark T. O'Donnell and staff to discuss my treatment and/or billing issues with the following individuals:

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____