

**McLEAN COUNTY NEUROLOGY, S.C.**  
 2204 EASTLAND DRIVE  
 BLOOMINGTON, ILLINOIS 61704  
 (309) 662-9461

Herman J. Dick, Jr., M.D.

Curtis J. Hayden, M.D.

Fang Li, M.D.

William H. Raino, M.D.

PATIENT'S NAME (LAST, FIRST, MI)		AGE	BIRTH DATE	SEX M F	MARITAL STATUS S M W D
ADDRESS		CITY	STATE	ZIP CODE	
HOME PHONE ( )	WORK PHONE (PATIENT) ( )		MAY WE CONTACT YOU AT WORK? (PLEASE CIRCLE) YES NO		
CELL PHONE ( )	EMAIL				
EMPLOYER (PATIENT)			SOCIAL SECURITY # (PATIENT)		
SPOUSE'S NAME	EMPLOYER (SPOUSE)		WORK PHONE (SPOUSE) ( )		

**COMPLETE THIS SECTION IF PATIENT IS A CHILD**

FATHER'S NAME	ADDRESS	PHONE ( )
FATHER'S EMPLOYER		PHONE ( )
MOTHER'S NAME	ADDRESS	PHONE ( )
MOTHER'S EMPLOYER		PHONE ( )

**INSURANCE INFORMATION**

INSURANCE COMPANY #1	NAME OF INSURED	BIRTH DATE OF INSURED / /
EMPLOYER NAME	PATIENT'S RELATIONSHIP TO INSURED (PLEASE CIRCLE) SELF SPOUSE CHILD	
INSURANCE COMPANY #2	NAME OF INSURED	BIRTH DATE OF INSURED
EMPLOYER NAME	PATIENT'S RELATIONSHIP TO INSURED (PLEASE CIRCLE) SELF SPOUSE CHILD	
INSURANCE CO. PREFERRED PROVIDER (PLEASE CIRCLE IF YOUR INSURANCE CO. REQUIRES YOU TO USE A SPECIFIC HOSPITAL)		
NONE	BROMENN	ST. JOSEPH
		ST. JAMES
		OTHER

SECONDARY CONTACT OUTSIDE THE HOME	PHONE ( )
PRIMARY CARE PHYSICIAN	PHONE ( )
REFERRING PHYSICIAN (IF DIFFERENT THAN PRIMARY)	PHONE ( )

CONTINUED ON REVERSE SIDE

**McLEAN COUNTY NEUROLOGY, S.C.**

IS TODAY'S VISIT DUE TO A WORK-RELATED INJURY?	(PLEASE CIRCLE)	YES	NO
IS TODAY'S VISIT DUE TO AN AUTO ACCIDENT?	(PLEASE CIRCLE)	YES	NO
IS TODAY'S VISIT DUE TO ANY OTHER TYPE OF LIABILITY?	(PLEASE CIRCLE)	YES	NO
<b>IF "YES" TO ANY OF THE ABOVE, PLEASE COMPLETE THE FOLLOWING:</b>			
DATE OF INJURY: _____		CLAIM #: _____	
NAME OF RESPONSIBLE PARTY: _____		PHONE #: (     ) _____	
ADDRESS OF RESPONSIBLE PARTY: _____			

**CONSENT FOR TREATMENT, RELEASE OF INFORMATION, RESPONSIBILITY OF PAYMENT**

**A. Consent to Medical Treatment**

I hereby consent for medical treatment and diagnostic procedures as may be deemed advisable for the course of treatment by McLean County Neurology, S.C. I acknowledge that no guarantees have been made to me as to the result of examination or treatment. I understand that the physician may request assistance from medically trained individuals who may be employees or agents of this facility. I understand that authorized medical, nursing and allied health professionals who are not employees of this facility may accompany and/or participate with the physician and staff in the observation and delivery of care and I consent to such participation.

**B. Release of information**

I understand that protected health information may be released to substantiate claims as outlined in the Privacy Notice provided to me by McLean County Neurology, S.C.  
McLean County Neurology, S.C. has the right to appeal any denial that may be made by my insurance company and has the right to receive complete documentation regarding any denials.

**C. Responsibility of Payment**

I understand that I am responsible for payment of services rendered by McLean County Neurology, S.C. regardless of any liability claims, insurance, lack of insurance, or insurance plan limitations. Such limitations may include, but are not limited to, pre-authorization or pre-certification programs, medical necessity limitations, and increased deductible or co-insurance amounts. I further agree to pay my account in full within 45 days from the date of first billing unless alternate reasonable arrangements are made with McLean County Neurology, S.C. In the event my account is sent to collections, I agree to pay a collection fee of \$25.00 in addition to my account balance.

I certify that I understand the content and significance of this form.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_