

# MATTEO CHIROPRACTIC PLLC

941 South Fifth Street  
Mebane, NC 27302  
Phone: 919-563-0000

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Street Address and Number: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex: Male Female # of Children \_\_\_\_\_ **Circle One:** Married Single Widowed Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

In case of emergency, please contact (include phone): \_\_\_\_\_

Please describe your condition(s) beginning with the most severe.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

When did this/these conditions begin? \_\_\_\_\_ Is the condition getting (circle) better worse same

What is the cause of your condition(s)? \_\_\_\_\_

What makes the condition feel better or worse? \_\_\_\_\_

Have you seen any other Physician for this condition? (Please list name and dates.) \_\_\_\_\_

Have you ever been treated by another chiropractor? (If yes, who/when/same condition?) \_\_\_\_\_

Have you ever had similar symptoms to present condition? \_\_\_\_\_

Are you currently treating with any other physician? (If yes, please explain.) \_\_\_\_\_

Please list your family Physician, location, (city and state), & Medications you are currently taking: \_\_\_\_\_

Please list your complete surgical history (give dates and types of surgery): \_\_\_\_\_

Have you ever been involved in an automobile accident? (If yes, please give dates & explain accident):

Name of person responsible for payment (if different from applicant) \_\_\_\_\_

Would you like to file insurance for you? (Please Circle) YES NO      Have you met your deductible? YES NO

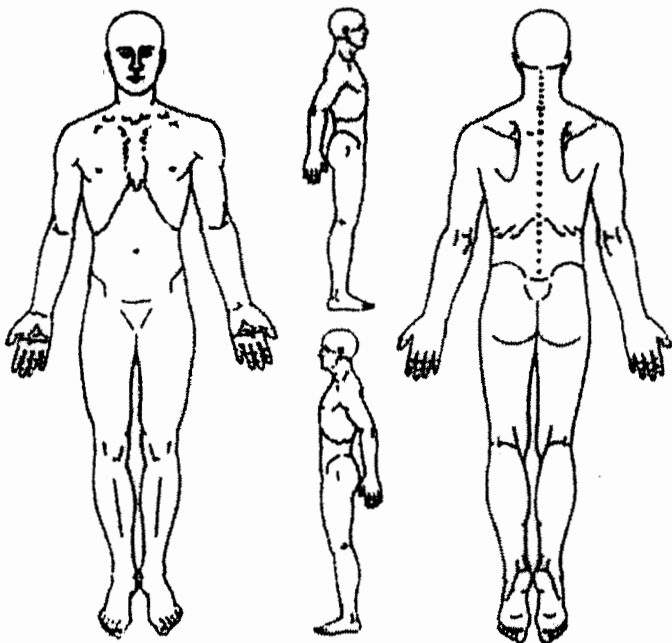
Name of insurance company (if applicable) \_\_\_\_\_

Name of Insured (if not self) \_\_\_\_\_ DOB of Insured \_\_\_\_\_

If you are experiencing any of the following conditions, please indicate on the diagrams below.

PLEASE CHECK THE SPACES BELOW FOR SYMPTOMS YOU ARE CURRENTLY HAVING.

**A=ACHE**      **B=BURNING**      **N=NUMBNESS**  
**P=PAIN**      **S=STABBING**      **O=OTHER**



1. \_\_\_\_\_ HEADACHES
2. \_\_\_\_\_ DIZZINESS
3. \_\_\_\_\_ NECK PAIN
4. \_\_\_\_\_ NECK STIFFNESS
5. \_\_\_\_\_ UPPER BACK PAIN
6. \_\_\_\_\_ SHOULDER PAIN
7. \_\_\_\_\_ ARM OR HAND PAIN
8. \_\_\_\_\_ NUMBNESS OR TINGLING
9. \_\_\_\_\_ MID BACK PAIN
10. \_\_\_\_\_ LOW BACK PAIN
11. \_\_\_\_\_ HIP OR BOTTOCK PAIN
12. \_\_\_\_\_ LEG OR FOOT PAIN
13. \_\_\_\_\_ EAR NOISES
14. \_\_\_\_\_ SINUS INFECTION
15. \_\_\_\_\_ VISION PROBLEMS
16. \_\_\_\_\_ ALLERGIES
17. \_\_\_\_\_ CHEST PAIN
18. \_\_\_\_\_ DIFFICULT BREATHING
19. \_\_\_\_\_ FREQUENT URINATION
20. \_\_\_\_\_ PROSTATE PROBLEMS
21. \_\_\_\_\_ ARTHRITIS
22. \_\_\_\_\_ BURSITIS
23. \_\_\_\_\_ STROKE

I hereby authorize Matteo Chiropractic PLLC to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the finders, and I wish all my chiropractic records be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THAT THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND CERTIFY THAT YOU PRESENT MATTEO CHIROPRACTIC PLLC FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

Signature of patient, or of Guardian authorizing care

Date

# MATTEO CHIROPRACTIC

PLLC

Dr. Craig Matteo

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible: \_\_\_\_\_) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here DR. MATTEO and or other licensed Physicians of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. MATTEO and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary, (e.g. If the patient is a minor or is physically or mentally incapacitated)

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Representative

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Representative

**This form should be maintained in the patient's health record.**



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**Dr. Craig M. Matteo**

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**Consent For Use Or Disclosure Of Health Information**

**OUR PRIVACY PLEDGE**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review the notice before you sign this consent form (165.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our policy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

**YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**YOUR RIGHT TO REVOKE YOUR AUTHORIZATION**

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to our health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Date



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**Appointment Reminders and Health Care Information Authorization**

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to our health information if they decide to contest any of our claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.





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## UPDATED INSURANCE VERIFICATION FORM

In accordance to the new Federal HIPPA guidelines the following information is needed to verify and process your insurance.

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_

Patient's Address (If different from Driver's License) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insured Subscriber Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_

Insured Relationship to Patient: \_\_\_\_\_

**Please Provide Your Chiropractic Assistant with a copy  
of your Insurance Card and Driver's License.**

# **MATTEO CHIROPRACTIC**

PLLC

Dr. Craig Matteo

## **CANCELLATION POLICY**

IT IS OUR OFFICE POLICY TO REQUEST A 24 HOUR NOTICE OF ANY APPOINTMENT YOU ARE UNABLE TO KEEP. FAILURE TO PROVIDE NOTICE WILL RESULT IN ADDITIONAL CHARGES TO YOUR ACCOUNT AS DESCRIBED BELOW:

### **MISSED APPOINTMENTS**

#### **CHIROPRACTIC:**

- 1<sup>ST</sup> TIME: GRACE
- 2<sup>ND</sup> TIME: \$20.00

#### **MASSAGE:**

- 1<sup>ST</sup> TIME: \$20.00
- 2<sup>ND</sup> TIME: 100% OF FEE (SEE BELOW)

EXAMPLE: IF YOU ARE BOOKED FOR A 30 MIN MASSAGE AND MISS YOUR APPOINTMENT, YOU WILL OWE THAT \$30.00.

### **REMINDER CALLS**

WHILE WE DO MAKE COURTESY REMINDER CALLS, IT IS ULTIMATELY **YOUR** RESPONSIBILITY TO ATTEND APPOINTMENTS THAT YOU HAVE BOOKED WITH OUR OFFICE.

*IF YOU DO NOT RECEIVE YOUR REMINDER CALL, THE MISSED APPOINTMENT POLICY APPLIES.*

**PATIENT SIGNATURE:**

**DATE:**

**WITNESS:**

941 S. Fifth St. Mebane, NC 27302 919.563.0000 office 919.563.0063 fax

[www.matteochiropractic.com](http://www.matteochiropractic.com)