Affinity Family Chiropractic, L.L.C.

Matthew Cecchetti, D.C., C.C.E.P.
7031 Crider Road, Suite 102▪ Mars, PA 16046

♦R E G I S T R A T I O N I N F O R M A T I O N ♦

PLEASE PRINT AND FILL IN COMPLETELY

PATIENT INFORMATION:

First Name_____ Middle Initial_____ Last Name_____

Preferred Name_____ Social Security Number _____

Home Phone_____ Cell Phone_____

Street Address_____City_____State_____Zip_____

Sex ☐ Male ☐ Female Birthdate_____Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Employed ☐ Retired ☐ Full-Time Student ☐ Part-Time Student ~ School _____

Employer _____Occupation_____Phone:_____

Employer Address_____City_____State____ Zip_____

☐ SPOUSE ☐ GUARDIAN or ☐ INSURANCE POLICY HOLDER'S INFORMATION (CHECK ONE)

First Name_____ Middle Initial_____Last Name_____

Social Security Number _____ Birthdate _____

Home Phone_____Street Address_____

City_____ State_____ Zip_____

Employer _____Occupation_____Phone:_____

Employer Address_____City_____State_____ Zip_____

Emergency Contact Person_____

Phone_____Relationship to Patient_____

(OVER)

Assignment and Release

I assign directly to Matthew Cecchetti, D.C., C.C.E.P. all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in this facility.

_____ _____

Signature of Insured/Guardian Date

Authorization for Chiropractic Treatment

I, _____ (patient's name), hereby authorize Dr. Matthew Cecchetti and the staff of Affinity Family Chiropractic, L.L.C. to perform diagnostic tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. As of the date stated below, I have the legal right to select and authorize health care services for the patient named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Affinity Family Chiropractic, L.L.C.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. I also certify that no guarantee or assurance has been made as to the results that may be attained.

_____ _____

Patient or Guardian Name (please print) Relationship to Patient

_____ _____

Patient or Guardian Signature Date

Privacy Statement

In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, post your name on the referral board, etc. Please let us know which form(s) of communication you would prefer to be contacted by. By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office. I may be contacted in the following manner (**check all that apply**):

Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Cell Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____
- ☐ O.K. to e-mail to _____

Other _____

_____

_____

_____ _____

Patient Name (please print) Date

_____ _____

Patient or Guardian Signature Relationship to Patient

_____ _____

Witness Date

Affinity Family Chiropractic ■ 7031 Crider Road, Suite 102 ■ Mars, PA 16046 ■ (724) 625-6325

office use_____