Elaine F. Mateo, M.D.
Confidential Patient Information

Patient Name: ____

Date of Birth: ____________________________ Age: ___________

Home Address: (No PO boxes): ____

City: __________________________ State: ____________ Zip: ____________

Home Telephone: _______________________________Cell Phone: ___________

Work Telephone: _______________________________ E-mail address: __________________________

At what number(s) may we leave a message? __________________________________

Emergency Contact (Name and Phone): ______________________________________

Marital Status: __________________________ Occupation: ________________

Employer: ____

Employer Address: ____

Referred by: ____

Billing Information

Person responsible for payment: ____

Address (include city/state/zip):
____

Home Telephone: _____________________ Work Telephone: ___________________

Cell Phone: _______________________________

If a Minor

Parent's marital status: _______________________________

Mother's Name: ___________________________

Home Address: ____

Best Contact Telephone #: ______________________ E-mail address: __________________________

Father's Name: _______________________________

Home Address: ____

Best Contact Telephone #: _______________________ E-mail address: __________________________

Elaine F. Mateo, M.D.
Billing and Cancellation Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THIS OFFICE IS NOT RESPONSIBLE FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. AN ATTENDING PHYSICIAN'S STATEMENT IS PROVIDED AT EACH OFFICE VISIT SO THAT YOU CAN ATTACH IT TO THE CLAIM FORM FROM YOUR INSURANCE CARRIER. **A FULL CHARGE IS MADE IF AN APPOINTMENT IS NOT CANCELED WITH AT LEAST 24 HOURS ADVANCE NOTICE.**

I have read the policies as stated in the above paragraph and I understand that I am responsible for payment and for following the cancellation policy.

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Signature Patient/Parent/Guardian

Consent for Services

I HEARBY AUTHORIZE AND VOLUNTARILY CONSENT FOR Dr. Elaine Mateo TO PROVIDE PSYCHIATRIC SERVICES CONSIDERED REASONABLY NECESSARY FOR MYSELF OR MY CHILD.

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Signature Patient/Parent/Guardian   Today's Date