Account #: _____

Stella Mattina
Phone: 214-942-3100
Fax: 469-399-0355
Bishop@stellamattina.com
Locations: 1135 North Bishop Avenue. Dallas, TX 75208 | 6300 Samuell Boulevard, #154. Dallas, TX 75228 /
811 W Interstate 20. Suite 212. Arlington, TX 76017

FINANCIAL WAIVER

Patient Name: _____

Date of Birth: ____/____/_____

I understand and agree that I am financially responsible for any and all medical services not covered by my insurance plan. It is my desire to receive medical services and pay the fees at the time services are being rendered.

Yo entiendo y estoy de acuerdo que soy económicamente responsable por los servicios médicos que no son cubiertos por mi plan de aseguranza. Es mi voluntad recibir y pagar los servicios médicos al momento de ser proporcionados.

Services requested: _____

_____

Servicios requeridos: _____

_____

_____ _____

(Patient PRINTED Name) (Patient Signature)

Date: ____/____/_____