Account #: _____

Stella Mattina Health Inc.
Phone: 214-942-3100
Locations: 1135 North Bishop Avenue. Dallas, TX 75208 | 811 W Interstate 20, Suite 212. Arlington, TX 76017 | 6300 Samuell Boulevard, #154. Dallas, TX 75228

PATIENT REGISTRATION

Patient's Name: _____

Status:_____ Date of birth:_____ Social Security Number: _____

Race:_____ Ethnicity:_____ Religion:_____

Address:_____ City:_____ State:_____ Zip code: _____

Cell Phone #:_____ Email:_____ Occupation:_____

Employer:_____ Employer Address:_____ Work Phone#: _____

Relative:_____ Relationship:_____ Cell Phone #: _____

Address:_____ City:_____ State:_____ Zip code: _____

RESPONSIBLE PARTY

Name:_____ Relationship:_____ Cell Phone #: _____

Date of birth:_____ Occupation:_____ Social Security Number: _____

Address:_____ City:_____ State:_____ Zip code: _____

Employer:_____ Employer Address:_____ Work Phone#: _____

INSURANCE INFORMATION

Medicare #:_____ Medicaid #:_____ Self Pay: _____

Preferred Pharmacy Name: _____

Address:_____ Phone #: _____

Insurance Company Name:_____ Phone #: _____

I.D Number:_____ Policy Group #: _____

Patient Referred by:_____ Allergies: _____

Reason for visit: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM REQUEST PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM TO BE MADE DIRECTLY TO WOMEN'S SPECIALTY CENTER AND/OR STELLA MATTINA HEALTH INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIMS. I AM ALSO AWARE THAT ACCORDING TO THE CONTRACT THAT I HAVE SIGNED WITH MY INSURANCE CARRIER CONSIDERED IT IS FRAUD NOT TO PAY MY COPAY OR DEDUCTIBLE AT THE TIME OF SERVICE. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

_____ _____

(Patient PRINTED Name) (Patient Signature)

Date: ____/____/_____

Authorization of Use and Disclosure of Protected Health Information (Page 1 of 2)

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. **In general, the HIPAA privacy rule gives the individuals the right to request a restriction of uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.**

I wish to be contacted in the following manner (check all that apply)

☐ Cell Telephone:_____

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

☐ 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

☐ Work Telephone:_____

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

☐ Email Communication: _____

- ☐ O.K. to email with detailed information
- ☐ Do not contact me by email

☐ Other: _____

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you noticed us of your decision. You have the right to request restrictions on use and disclosure of your health information.

I,_____, would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

Persons Authorized to Receive Information:
Health information that Women's Specialty Center and/or Stella Mattina Health Inc. collects or receives about you may be disclosed to the following persons:

_____
Name of person / relation / organization

_____
Name of person / relation / organization

Use and Disclosure of Information:

_____I authorize the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Women's Specialty Center and/or Stella Mattina Health Inc.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify).

_____

Expiration Date of Authorization
This authorization is effective through_____/_____/_____unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Women's Specialty Center and/or Stella Mattina Health Inc. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____

(Patient PRINTED Name) (Patient Signature)

Date: ____/____/_____

FINANCIAL WAIVER

PATIENT NAME:
NOMBRE DEL PACIENTE: _____

DATE OF BIRTH:
FECHA DE NACIMIENTO: _____

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 QUÉ SOY ECONOMICAMENTE RESPONSABLE POR LOS SERVICIOS MEDICOS QUÉ NO SON CUBIERTOS POR MI PLAN DE ASEGURANZA. ES MI VOLUNTAD RECIBIR Y PAGAR LOS SERVICIOS MEDICOS AL MOMENTO DE SER PROPORCIONADOS.

SERVICES REQUESTED: _____

_____

SERVICIOS REQUERIDOS: _____

_____

_____ _____

(Patient PRINTED Name) (Patient Signature)

Date: ____/____/_____