






# WOMEN'S SPECIALTY CENTER

Dallas, TX  
(214) 942 - 3100   
contact@wscdallas.com   
www.womens-specialty-center.com 

## PATIENT INFORMATION

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. 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 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:

\_\_\_\_\_  
\_\_\_\_\_



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

**Persons Authorized to Receive Information:**

Health information that Women's Specialty Center 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.

\_\_\_\_\_ 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. 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 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth



---

## 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: \_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF PATIENT  
FIRMA DEL PACIENTE

SIGNATURE OF RESPONSIBLE PARTY  
FIRMA DEL RESPONSABLE

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Fecha: \_\_\_\_\_