Account #: ________________

Stella Mattina Health Inc.

Phone: 214-942-3100 Fax: 469-399-0355

Locations: 1135 N Bishop Ave. Dallas, TX 75208 | 6300 Samuell Blvd, #154. Dallas, TX 75228 | 901 N. Galloway Ave. Ste 107. Mesquite, TX. 75149 | 811 W Interstate 20 Ste 212. Arlington, TX 76017 |

PATIENT REGISTRATION

Patient's Name: ____

Marital Status:______________Date of Birth:______________Social Security Number: ______________

Race: ______________Ethnicity:______________Religion:______________

Address:______________ City:______________State:________Zip Code:______________

Cell Phone #:______________Email:______________Occupation:______________

RESPONSIBLE PARTY

Name:______________________Relationship:______________Cell Phone #:______________

Date of Birth:______________ Occupation:______________ Social Security Number: ______________

Address:______________________ City:______________State:________Zip Code:______________

ADDITIONAL INFORMATION

Preferred Pharmacy Name: ____

Address:______________________________________ Phone #: ______________

Reason for visit: ______________________Allergies: ______________________

Patient Referred by:

☐ Search ☐ Post card ☐ Social Media ☐ Physician Referral: ____________ ☐ Other ____________

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 PRINTED Name) (Patient Signature)

Date: ___/___/____

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 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

☐ Email:____

- ☐ 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

Persons Authorized to Receive Information:

Health information that 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 Stella Mattina Health Inc Clinics.

________ 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 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: ____

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.

Services requested: ____

______________________________	______________________________
(Patient Printed Name)	(Patient Signature)

Date: ____/____/_____