Cheryl Potter, M.D.
3090 Ridge Road

Julia R. Gillean, M.D.
Rockwall, TX 75032

Amy Hantes, W.H.N.P.-B.C.
(972) 475-9505

PATIENT INFORMATION:
Please print clearly and fill out completely: Primary Care Physician_____ Referred By_____

Name_____
First Middle Last

Address_____
Street Apt City State Zip

Primary Phone (___)_____(**Please circle**) Home/Work/Cell Secondary Phone (___)_____(**Please circle**) Home/Work/Cell

Communication Preference: (circle one) **e-mail phone letter E-Mail Address:**_____

Date of Birth___/___/_____Age_____ Social Security #_____Driver License_____State___

Name of Employer_____Phone #(___)_____

Address_____City_____State_____Zip_____

Martial Status_____ Spouse/Significant Other's Name_____Date of Birth___/___/___

Primary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____City_____State_____Zip_____

Name of Insured_____ Relationship to Patient_____

Insured's Information:

Date of Birth___/___/___ Insured's Social Security #_____Member #_____Group #_____

Insured's Employer_____Phone #(___)_____

Insured's Employer Address_____City_____State_____Zip_____

Secondary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____City_____State_____Zip_____

Name of Insured_____ Relationship to Patient_____

Insured's Information:

Date of Birth___/___/___ Insured's Social Security #_____Member #_____Group #_____

Insured's Employer_____Phone #(___)_____

Insured's Employer Address_____City_____State_____Zip_____

Nearest Friend or Relative Not Living With You (In case of an emergency)

Name_____Relationship to Patient_____

Home Phone(_____)_____ Mobile(_____)_____

HIPAA Consent to Release Medical Information

I give the physicians and staff of Metroplex Women's Care permission to discuss all aspects of my personal health history, condition and treatment with:

_____ Relationship: _____

_____ Relationship: _____

If you do not wish to share any medical information with anyone, please check here. _____ (NO ONE)

Signature_____Date_____/_____/_____

Metroplex Women's Care

Dr. Cheryl A. Potter
Dr. Julia R. Gillean
Amy Hantes, WHNP-BC
3090 Ridge Road
Rockwall, TX 75032
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Notice to Patients of Physician Ownership in Hospital

You are hereby informed that Dr. Cheryl Potter and Dr. Julia Gillean own an interest in Texas Health Presbyterian Hospital Rockwall, (the "Hospital") which is a physician-owned hospital as that term is defined under federal law and regulations. Any of your treating physicians may also own a financial interest in the Hospital. Upon request, the Hospital will provide you with a list of the Hospital's owners and investors that are physicians or immediate family members of physicians.

By your signature below, you acknowledge receipt of this Notice to Patients of Physician Ownership in Hospital and further acknowledge that you have been given this notice in a sufficient amount of time in advance of any procedure or surgery at the Hospital or admission to the Hospital to make a meaningful decision regarding your receipt of care.

_____
Patient Signature

_____
Witness Signature

Metroplex Women's Care

Dr. Cheryl A. Potter *Dr. Julia R. Gillean* *Amy Hantes, WHNP-BC*
3090 Ridge Road *Rockwall, TX 75032* *(972) 475-9505*

General Consent for Medical Treatment

I, _____, authorize and direct the practitioners of Metroplex Women's Care, Dr. Cheryl A. Potter and Dr. Julia R. Gillean and nurse practitioner Amy Hantes, to render medical care as determined necessary at the time of service.

_____ _____
Patient's Signature Date

_____ _____
Witness's Signature Date

Patient acknowledgement of receipt of our Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____
Patient's Signature Date

_____ _____
Witness's Signature Date

Metroplex Women's Care

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Dear Patient:
I am informing you in advance that a service may not be covered because your insurance company may determine that it is not "reasonable and necessary." Although this wording implies that such services are not medically necessary and/or routine, we must emphasize that, in our professional judgments, these services are needed in order to render high quality care to you.

The following are some guidelines that may result in the denial of service(s).

- Expenses are not payable due to Employer Plan Provisions:
  - Plan maximum has been met or services not covered under plan provisions
  - Not eligible for coverage on the date(s) services rendered
  - Routine physical or other preventative services and other examinations
- Payment reflects carrier's determination of the usual & customary charge for this service
- Expenses are not payable due to other benefit limitations on this plan and are the responsibility of the insured
- Routine/Preventative services are not covered
- Pre-existing conditions may not be covered
- Other_____

By signing this statement, you are agreeing to pay for service(s) rendered, even if your insurance carrier determines that, according to its guidelines, the services are not "reasonable and necessary."

I hereby assign, transfer and set over to Julia Gillean, MD and Cheryl Potter, MD all of my rights, title and interest to my medical reimbursement benefits under my insurance policy, including Medicare, and other government sponsored programs, private insurance and any other health plan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

_____
Print Patient Name

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date

_____ _____
Witness's Signature Date