RIVERSTONE MEDICAL ASSOCIATES: YOUR PRIMARY CARE PLLC

7070 Knights Ct Unit 1405, Missouri City, TX 77459

Ph: 346-447-6622 Fax: 346-202-0093

PATIENT FORMS

BASIC INFORMATION

Full Name: _____
First Middle Last

Sex: ☐ Male ☐ Female Date of Birth: _____

Phone Number/Email: _____

Social Security Number: _____

Address Line: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Driver's License State/Number: _____

EMERGENCY CONTACT

Relationship to Contact: _____

Full Name: _____

Phone Number/Email: _____

FINANCIAL INFORMATION

Responsible Party

Who will be financially responsible for you? ☒ Myself ☐ Someone else (If so, fill out below)

Relationship to Contact: _____ Full Name: _____

Phone Number: _____

Method of Payment: ☐ Insurance ☐ Self-Pay

PRIMARY INSURANCE POLICY (If you chose insurance, fill out below)

Insurance Company: _____

Policy Number: _____

Group Number: _____

Relationship to Primary Policy Holder (If you are not the primary policy holder, fill out below)

Full Name: _____ Date of Birth: _____

SECONDARY INSURANCE POLICY (If applicable)

Insurance Company: _____

Policy Number: _____

Group Number: _____

How did you hear about us?

INFORMED CONSENT FOR THE TREATMENT

Patient Name: _____ Date of Birth: _____

Consent for Treatment: I, the undersigned, authorize Your Primary Care PLLC ("Provider") and its authorized healthcare professionals to perform medical evaluations, diagnostic tests, and treatment as deemed necessary or advisable for my care. This may include, but is not limited to, physical examinations, laboratory tests, imaging studies, and procedures. I understand that this consent applies to all routine and emergency care.

Acknowledgment of Risks and Benefits: I acknowledge and understand all medical procedures and treatments involve potential risks, including but not limited to infection, bleeding, allergic reactions, and unforeseen complications. My provider will explain the specific risks, benefits, and alternatives, for proposed treatments or procedures.

No Guarantees: While my healthcare providers will make every effort to ensure the best outcomes, no guarantees or promises have been made regarding the results of treatments or procedures.

Consent to Use and Share Health Information: I understand that my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPPA) and Texas state privacy laws. This includes sharing information for treatment, payment, and healthcare operations.

Consent to Emergency Treatment: In the event of a medical emergency, I authorize the Provider to administer necessary live-saving treatment without prior approval.

Patient Rights: I understand that I have the right to be informed about the nature and purpose of any proposed treatment or procedure, ask questions and seek clarification about my care, and decline or withdraw my consent at any time, understanding that this may affect the care I receive.

Financial Responsibility: I accept full financial responsibility for all services provided unless otherwise covered by insurance or an approved financial assistance program. I understand that I may receive separate bills for services rendered by laboratories, imaging centers, or other third parties.

Special Consent Requirements: Certain procedures (e.g., surgery, anesthesia, or experimental treatments) may require additional written consent, which will be obtained before proceeding.

Voluntary Consent: I certify that I have read (or have read to me) and understand the information provided above. I have had the opportunity to ask questions and receive answers. I voluntarily consent to treatment as described in this form. I hereby authorize **Your Primary Care PLLC** and its providers or designated physician/staff to give treatment and/or recommend advice in the course of my diagnosis.

Please sign your name below Date: _____

X_____

I am the parent/guardian of this patient (relationship)

INFORMED CONSENT FOR TELEMEDICINE

Patient Name: _____ Date of Birth: _____

Telemedicine involves the use of secure electronic communication (audio, video, images, and medical records) to provide healthcare services remotely.

Privacy (HIPAA)
Telemedicine services are provided in compliance with the **Health Insurance Portability and Accountability Act (HIPAA)**. Reasonable safeguards are used to protect the privacy and security of your health information; however, no system is completely risk-free.

Benefits & Risks

Benefits: Convenient access to care and timely medical evaluation.
Risks: Technical issues, limited clinical information, or rare privacy/security breaches that may affect care.

Patient Acknowledgment

By signing below, I acknowledge that:

- Telemedicine is voluntary and I may withdraw consent at any time without affecting future care.
- My health information is protected under HIPAA and applicable Texas law.
- I may access and request copies of my medical records.
- Alternative care options are available.
- I will be physically located in **Texas** during all telemedicine encounters with **Your Primary Care PLLC**.
- No specific medical outcomes are guaranteed.

Notice of Privacy Practices

I acknowledge receipt or availability of **Your Primary Care PLLC's Notice of Privacy Practices**. **EHR Consent:** I consent to receive healthcare services via telemedicine.

Signature: _____ Date: _____

NOTICE OF PATIENTS' PRIVACY RIGHTS

Patient Name: _____ Date of Birth: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Our Commitment to Your Privacy

Your Primary Care PLLC is committed to protecting the privacy of your **Protected Health Information (PHI)**. PHI includes information that identifies you and relates to your health, healthcare, or payment for services.
We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice currently in effect

This Notice applies to all records created or maintained by our Practice. We reserve the right to revise this Notice at any time. Any revised Notice will apply to all PHI we maintain and will be made available upon request and posted in our office.

How We May Use and Disclose Your PHI

Treatment
We may use and disclose your PHI to provide, coordinate, or manage your healthcare. This may include sharing information with physicians, nurses, specialists, laboratories, pharmacies, and other healthcare providers involved in your care.

Payment
We may use and disclose your PHI to obtain payment for healthcare services. This may include billing insurance companies or other responsible parties. You may request that we not submit claims to your insurance; however, you will be responsible for full payment.

Healthcare Operations
We may use your PHI for healthcare operations, including quality improvement, training, accreditation, licensing, auditing, and business management activities.

Appointment Reminders and Health Information
We may contact you to remind you of appointments or to provide information about treatment options, alternatives, or other health-related services that may benefit you.

Family and Others Involved in Your Care
With your authorization, we may disclose PHI to family members, friends, or others involved in your care or payment. Written authorization is generally required unless otherwise permitted by law.

Disclosures Required by Law
We may disclose your PHI when required by federal, state, or local law.

SPECIAL CIRCUMSTANCES

We may disclose PHI without your authorization for:

- Public health activities (including reporting abuse, neglect, or communicable diseases)
- Health oversight activities (such as audits or investigations)
- Law enforcement purposes
- Serious threats to health or safety
- Military, national security, correctional, or custodial situations
- Workers' Compensation or similar programs

All disclosures will be limited to the minimum necessary as required by law.

Your Rights Regarding Your PHI

You have the right to:

- Access and obtain copies of your medical records
- Request amendments to your PHI
- Request restrictions on certain uses or disclosures
- Request confidential communications
- Receive an accounting of certain disclosures
- Obtain a paper copy of this Notice
- Revoke authorizations in writing at any time

Requests must be submitted in writing in accordance with Practice policies.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the **U.S. Department of Health and Human Services**. You will not be penalized for filing a complaint.

Regulatory Compliance
This Notice complies with the **HIPAA Privacy Rule (45 CFR Parts 160 & 164)** and applicable **Texas Medical Board regulations**.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of the **Notice of Privacy Practices** for Your Primary Care PLLC.

Signature: _____
Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Including Medical and Mental Health Records

Patient's Name: _____ **Date of Birth:** _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Your Primary Care PLLC Dba Riverstone Medical Associates

Address: 7070 KNIGHTS COURT UNIT# 1405, Missouri City, TX 77459

Phone #: 346-447-6622 Fax #: 346-202-0093

Federal Regulation, 42 CFR Part 2, requires that a description of the amount, the kind of information that is to be disclosed and the purpose for this disclosure.

This request and authorization apply to: ☐ All records available, or the specific records indicated here:

☐ Psychiatric Evaluation/Testing ☒ Diagnosis/Treatment

☐ History/HPI/Progress Note ☐ School Evaluation

☐ Legal Issues/Concerns ☐ Hospitalization/Outpatient Care

☐ Other: (specify) _____

and is to be released for the purpose of: ☒ Continuity of care ☐ Other: (specify) _____

By checking the boxes below, I specifically authorize the voluntary release of the following types of medical records, if such records exist.

☒ Yes ☐ No I authorize the release of my HIV/AIDS records, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition, on which permission will expire:

_____.

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent at any time to the extent that information has already been released based on this authorization.

Patient Signature: _____ Date Signed: _____

Relationship to Patient: _____

CREDIT CARD AUTHORIZATION FORM

Riverstone Medical Associates: Your Primary care PLLC
7070 Knights court, Unit 1405, Missouri city, TX, 77459
Ph: 346-447-6622 Fax: 346-202-0093

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email: _____

Credit Card Details

- Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
- Cardholder Name (as it appears on card): _____
- Card Number: _____
- Expiration Date (MM/YY): _____
- CVV: _____

Billing Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Authorization

I authorize **Riverstone medical associates** to charge my credit card for the following:
I understand that:

- This authorization will remain in effect until I cancel it in writing.
- I am responsible for updating any changes to my payment method.
- Charges will appear on my statement as **Your Primary Care PLLC/ Riverstone medical associates**.
- This form will be securely stored in compliance with HIPAA and PCI standards.
- If insurance deny any claim for any reasons or any overdue, I am responsible for the full payment without any discount.
- Additional travel expenses may be charged by the provider even if the insurance pay for the visit.

Cardholder Signature

Signature: _____
Date: ___ / ___ / ____