



Patient Name: _____

DOB: ____ / ____ / ____

New Patient Registration

Patient Information			Office use: copy photo ID
Last Name	First Name	Middle Name	
Date of Birth ____ / ____ / ____	Social Security Number		
Sex ☐ Male ☐ Female ☐ Trans/Other	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Mobile Phone ()	Preferred Language	Ethnicity Race	
Current Street Address	City	State / ZIP Code	
Email Address		Patient Portal ☐ Send me a portal invitation	
Insurance Information			Office use: copy insurance card (front and back)
Primary Insurance		Contract #	
Secondary Insurance		Contract #	
Subscriber's Name		Relationship to Patient	
Emergency Contact / Release of Information			
Name	Relationship to Patient	Phone ()	
Notes			Office use

Patient Name: _____

DOB: ____ / ____ / ____

Patient Consent and Acknowledgments

General Consent to Treatment

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my physician, non-physician practitioner (PA-C/CNP), their assistants or designees at River Oaks Primary Care may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, specialty referrals, and routine medical care. I authorize my physician(s) or provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/provider and that other personnel render care and services to me according to the physician's instructions.

I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees or promises have been made to me with regard to the results of such diagnostic procedures or medical treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures, and I authorize River Oaks Primary Care to properly dispose of these samples.

I have been informed and understand that an HIV (Human Immunodeficiency Virus/AIDS) test may be performed on me without my consent if a health professional or clinic employee sustains an exposure to my blood or other body fluid.

I acknowledge that I have read or have had read to me this consent, and fully understand its details. I have had the opportunity to ask questions and have had these questions addressed.

Assignment of Benefits

I hereby assign and request that payment of authorized insurance benefits, including Medicare/medical insurance if applicable, be made on my behalf to River Oaks Primary Care for any medical services provided via telemedicine or in person.

I authorize the release of any medical or other information necessary to determine these benefits, or the benefits payable for related equipment or services, to the Centers for Medicare and Medicaid Services or any other insurance carrier with whom I have coverage.

I understand that I am financially responsible to River Oaks Primary Care for any charges not covered by health care benefits, and I am only responsible for any deductible, co-pay, or other amounts for services not covered by my insurance. I understand that River Oaks Primary Care agrees to accept the payment made by Medicare and any other insurance coverage as its full charge. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify River Oaks Primary Care of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

I acknowledge that I have read or have had read to me this assignment of benefits, and fully understand its details. I have had the opportunity to ask questions and have had these questions addressed.

HIPAA Patient Consent and Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information. The notice contains a patient's rights section describing your rights under the law. By signing this form, you confirm that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Patient Name: _____

DOB: ____ / ____ / ____

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time, and all future disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

We may also contact you in the following ways:

- We may confirm appointments by phone, text, or email.
- We may leave a message on your home or mobile phone.
- We may invite you to participate in our Patient Portal.

Artificial Intelligence (AI) Documentation

Our clinic uses a software tool to create notes for your medical record. Using this software helps your doctor focus on talking with you and caring for you, instead of typing at the computer.

This tool records what you and your doctor say during your appointment and uses AI to write a summary for your doctor to review. Your doctor can edit the summary before it is added to your medical record.

This software does not keep the recording of your appointment, and it encrypts the information it stores to protect your privacy. Your personal health information and the recording of your appointment will not be used to train AI.

More detailed information about how this tool handles your information is available on request. You may also ask your doctor or clinic staff any questions about this tool and how it is used in our clinic.

I agree to the use of this AI documentation software.

Telehealth and HIPAA Consent

By signing this form, I understand and agree with the following:

Telehealth/telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants, and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives, or guardians. The information may be used for diagnosis, therapy, follow-up, and/or education.

Telehealth/telemedicine requires transmission, via Internet or telecommunication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data and prescription information transmitted electronically
- Videos, pictures, text messages, audio, and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to River Oaks Primary Care sharing my protected health information with certain third parties as more fully described in the River Oaks Primary Care Privacy Policy. I understand, agree,



Patient Name: _____

DOB: ____ / ____ / ____

and expressly consent to River Oaks Primary Care obtaining, using, storing, and disseminating to necessary third parties information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session so that they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient, or care team.

I hereby release and hold harmless River Oaks Primary Care and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at River Oaks Primary Care.

Signature

This Consent, Assignment of Benefits, and Acknowledgment was signed and agreed to by:

Patient Name (please print)

Date of Birth

Patient or Legal Representative Signature

Date

Witness (if necessary)

Date

HIPAA Authorization Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to establish national standards for the protection of sensitive patient health information. HIPAA ensures that patient information is kept confidential and is not disclosed without the patient's consent or knowledge, except in specific situations as outlined by the law.

Permitted Uses and Disclosures

Under HIPAA, a covered entity is permitted, but not required, to use and disclose Protected Health Information (PHI) without an individual's authorization for the following purposes:

1. Disclosure to the Individual

- A covered entity must disclose PHI to the individual if the information is needed for access or accounting of disclosures.

2. Treatment, Payment, and Healthcare Operations

- PHI can be disclosed for purposes of treatment, payment, and healthcare operations without individual authorization.

3. Opportunity to Agree or Object

- A covered entity can obtain informal permission to disclose PHI by directly asking the individual, or by circumstances that give the individual the opportunity to agree, acquiesce, or object to the disclosure.

4. Incident to an Otherwise Permitted Use or Disclosure

- PHI may be disclosed incidentally to other permitted uses.

5. Limited Data Set for Research, Public Health, or Healthcare Operations

- PHI may be disclosed in limited form for research, public health, or healthcare operations when permitted.

6. Public Interest and Benefit Activities

- HIPAA allows PHI disclosures for certain public interest and benefit activities without the individual's authorization. These include:
 - When required by law
 - Public health activities
 - Victims of abuse, neglect, or domestic violence
 - Health oversight activities
 - Judicial and administrative proceedings
 - Law enforcement
 - Deceased persons (e.g., organ, eye, or tissue donation)
 - Research (under certain conditions)
 - To prevent or lessen a serious threat to health or safety
 - Essential government functions
 - Workers' compensation

HIPAA Security Rule

While the HIPAA Privacy Rule protects the confidentiality of PHI, the **HIPAA Security Rule** specifically safeguards electronic Protected Health Information (e-PHI). e-PHI refers to individually identifiable health information that is created, received, maintained, or transmitted in electronic form.

The Security Rule requires covered entities to:

- Ensure the confidentiality, integrity, and availability of e-PHI.
- Implement safeguards to protect against anticipated threats to the security of e-PHI.
- Safeguard against unauthorized uses or disclosures of e-PHI.

-
- Certify compliance with these requirements by the workforce.

The Security Rule does not apply to PHI transmitted orally or in writing.

Compliance and Enforcement

Covered entities must rely on professional ethics and best judgment when considering requests for uses and disclosures of PHI. The U.S. Department of Health and Human Services (HHS) Office for Civil Rights enforces HIPAA regulations. Violations of HIPAA may result in civil and criminal penalties.



Authorization to Release Medical Information

Patient Name

Date of Birth

I, _____, give authorization to River Oaks Primary Care PLLC and all personnel employed by River Oaks Primary Care PLLC to release my medical information to the recipients listed below:

Recipient Name	Relationship to Patient	Phone Number

I have read and understand the HIPAA policy and the permitted uses and disclosures. I agree to allow my healthcare providers to use and share my health information as necessary for my treatment, payment, and healthcare operations while protecting my privacy and confidentiality.

Patient or Legal Representative Signature

Date

Consent to Obtain Outpatient Records

I, _____, date of birth ____ / ____ / _____, am a patient of River Oaks Primary Care PLLC. I authorize the employed providers listed below to access any medical records regarding my care from all medical offices, hospitals, and facilities that have provided me care.

Providers

- Dr. Redwan Asbahi, MD
- Kay Elder, FNP-C
- Dr. Maha Abu-Khdeir, MD

Patient or Legal Representative Signature

Date

Print Name

Date of Birth

Office Policies and Procedures for Our Patients

Thank you for choosing River Oaks Primary Care PLLC. Our staff strives to exceed expectations in care and service and to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care promptly. To do so, we have implemented the policies and procedures below, which help us make the best use of available appointments for patients in need of medical care.

Office Hours

Our office is open Monday through Friday, 9:00 a.m. to 5:00 p.m. We see our last patient at 4:00 p.m. We can be reached at (313) 336-4444. Our physicians are available after hours, 24 hours a day, 365 days a year, by calling our phone number and following the prompts. If you need an appointment, prescription refill, or test results, please call during regular business hours.

Walk-In Visits

We offer walk-in appointments for our patients during regular business hours. Please be mindful that walk-in patients should expect a wait, as there are patients with scheduled appointments. Our goal is to provide urgent medical care within one hour for acute illness.

Appointments

River Oaks Primary Care PLLC is committed to providing quality care to our patients. To ensure timely, continued care, we encourage patients to schedule follow-up appointments in advance of their due dates. We always try to schedule these after your visit, so please stop by the front desk before leaving the office. When calling for an appointment, please provide your name and date of birth, your chief complaint or reason for the visit, and any updated contact and insurance information.

While we strive to schedule appointments appropriately, emergencies can and do occur in primary care. We strive to give all our patients the time they require. For this reason, we kindly ask for your patience and understanding should a delay or rescheduling become necessary on your appointment date.

To ensure quality care, River Oaks Primary Care PLLC does not treat patients who have not been seen (for example, we will not call in prescriptions or offer medical advice before the initial visit). A follow-up visit may be required after testing is completed so that results can be reviewed together and an effective, appropriate plan for your healthcare can be determined.

We encourage you to schedule appointments for preventive health visits, physicals, Pap exams, chronic medical conditions, prescription renewals, and sick visits.

Cancellations

Out of respect for the medical needs of all our patients, please call River Oaks Primary Care PLLC promptly if you are unable to attend an appointment. Your appointment time will be given to someone who needs treatment. This is how we can best serve the needs of our patients.

If you need to cancel your scheduled appointment, we require that you call one working day in advance (24 hours before your scheduled time; if your appointment is on a Monday, please call the Friday before). Appointments are in high demand, and early cancellation gives another person access to timely care. **Appointments canceled on the day of the appointment are subject to a \$10 fee.**

No-Shows

A "no-show" is a patient who misses an appointment without canceling it before the appointment time. No-shows inconvenience other patients who need prompt access to medical care.

A failure to arrive for a scheduled appointment will be recorded in your medical chart as a no-show, and **an administrative fee of \$25.00 will be billed to your account.** You will be sent a letter notifying you that you missed a scheduled appointment without canceling within one working day, and a copy will be placed in your medical record.

Three consecutive no-shows are subject to discharge from the practice. In that case, you will receive a letter, and you will be required to schedule a visit for the provider to evaluate your situation. This evaluation includes a review of your past appointment history, balance history, and compliance with medical care. Based on this review, the provider may discharge you from the practice. If you do not schedule this evaluation within 30 days of the letter, your patient status will be terminated.

Please note: no-show charges are the patient's responsibility and will not be billed to your health insurance.

Insurance

River Oaks Primary Care accepts most insurance plans, but there are some we do not accept. It is your responsibility to contact your insurance company and confirm that we are in-network with your specific plan. It is also your responsibility to make sure, before your appointment, that our providers are listed as your Primary Care Physician. **If this is not completed before your appointment, we will cancel the appointment and you will be charged a \$10 administrative fee.**

Payments

River Oaks Primary Care PLLC accepts cash, checks, Mastercard, American Express, and Visa. Checks should be made payable to River Oaks Primary Care PLLC. It is our policy to make all reasonable attempts to collect outstanding balances, should they accrue, including offering convenient payment arrangements.

Forms and Letters

We understand that various forms or letters may be required to assist you with your healthcare needs. Our staff will be happy to complete forms and write medical letters upon request. **There is an administrative fee of \$35.00, due at the time of the request.** Please allow 7–10 business days for completion.

Please keep in mind that some forms require you to be seen by the provider. **That office visit costs \$80.00, is due at the time of service, and will not be billed to your health insurance.**

Medical Records

Under HIPAA guidelines, requests for copies of medical records must be made in writing. To protect your privacy, a release of medical information form must be completed before records are provided. All patients may request one copy of their medical records free of charge; additional copies are \$0.75 per page. The law allows medical offices 30 days to complete records requests; however, our medical records department makes every effort to respond promptly.

Please also note that your provider may obtain or access medical records from outside facilities or providers to ensure the best possible care.

Prescription Refills and Pharmacy Information

Please tell us which pharmacy you use and let us know if it changes. Please allow one to two business days for refill requests. We encourage patients to review their medications before office visits and to request any needed refills at that time.

Please note: we do NOT refill narcotic medications or prescribe antibiotics over the phone. Our practice does not routinely prescribe narcotic pain medicine, so you may be required to obtain these medications through pain management.



Office Policies and Procedures — Patient Acknowledgment

Please sign and return this page to the front desk.

Patient Name (please print)

Date of Birth

I, the patient, have read and reviewed the River Oaks Primary Care PLLC Office Policies and Procedures and agree to abide by them.

Patient or Legal Representative Signature

Date

Patient Financial Policy

Thank you for choosing River Oaks Primary Care PLLC as your healthcare provider. We are dedicated to delivering exceptional care and to making your experience with us as smooth and stress-free as possible. An important part of this relationship is your clear understanding of our Patient Financial Policy. Please carefully review the following policies regarding financial responsibility for services rendered.

Insurance Participation

We participate in most major insurance plans, including Medicaid and Medicare. However, if you are insured by a plan in which we do not participate, full payment is required at the time of service. If your insurance coverage cannot be verified at the time of your visit, you will be required to pay in full until we can confirm your coverage.

It is your responsibility to ensure that River Oaks Primary Care PLLC is listed as your Primary Care Provider (PCP). If we are not listed as your PCP and your insurance does not cover the visit, you will be responsible for full payment. If you choose to cancel your appointment due to an insurance issue, you will incur a \$10 administrative fee for late cancellation.

Copayments, Deductibles, and Coinsurance

All copayments, deductibles, and coinsurance are due at the time of service. This requirement is part of your agreement with your insurance company. Failure to collect these amounts at the time of service is considered non-compliance with the law. We accept Mastercard, Visa, American Express, cash, and checks.

A \$35 fee will be assessed for any returned check, payable by cash or money order, in addition to the amount of the check. After a returned check, you may be placed on a cash-only basis for future visits.

Non-Covered Services

Some services may not be covered by your insurance plan or may not be considered medically necessary by Medicare or other payers. In these cases, you will be responsible for paying for these services in full.

Proof of Insurance

All patients are required to complete the patient information form before being seen by a provider. We must obtain a copy of your current insurance card and driver's license to verify your insurance coverage. Failure to provide accurate and timely insurance information may result in the patient being responsible for the balance of the claim.

Claims Submission

We will submit insurance claims on your behalf and assist with the claims process. However, your insurance provider may request additional information directly from you, and it is your responsibility to respond to such requests promptly. Ultimately, the balance of any claim is your responsibility, whether or not your insurance company pays the claim. Your insurance benefit is a contract between you and your insurance provider; we are not a party to that contract.

Coverage Changes

If your insurance coverage changes, please notify us before your next appointment so we can update your information and help you receive the maximum benefits available under your plan. If your insurance company does not pay your claim within 45 days, the balance will be billed directly to you.

Nonpayment

Accounts that remain unpaid will receive up to three statements. If payment is not received, we reserve the right to withhold future services until payment is made. We offer payment plans and are happy to work with you to accommodate your financial situation.

If no payment is received within six months of the date of service, you may be discharged from our practice and notified by letter to seek alternative care. During the 30-day notice period, we will provide emergency care only. If payment is not received or no arrangements are made within those 30 days, your patient status will be terminated.

Self-Pay Accounts

Self-pay patients are those without insurance, those with insurance plans in which we do not participate, and those without an insurance card on file. We do not accept payment through attorney letters or contingency-based payments. It is the patient's responsibility to verify whether our office participates in their insurance plan. If there is a discrepancy with insurance information, the patient will be considered self-pay unless proven otherwise.

Minors

The parent or guardian of a minor is financially responsible for the cost of care and will receive all billing statements. A signed release may be required to treat unaccompanied minors.

No-Show and Cancellation Policy

It is your responsibility to cancel or reschedule appointments at least 24 hours in advance. **Same-day cancellations without a valid emergency reason incur a \$10 late cancellation fee. Missing an appointment without prior notice incurs a \$25 no-show fee.**

After three consecutive no-shows, you will be required to schedule an appointment with the provider to evaluate your situation. During the evaluation, the provider will review your medical history, attendance, and compliance with payments and care recommendations to determine whether continued care is appropriate. If you do not respond to the request for an evaluation within 30 days, your status as a patient will be terminated, and you will receive a letter notifying you of this decision.

Patient Responsibility for Payment

Regardless of any arrangements you may have with other parties, if you are 18 years of age or older and receiving treatment, you are ultimately responsible for payment. We will not bill any other individual or party outside the terms of your health insurance. Our practice strives to offer the best care possible at reasonable and customary rates for our area.

We appreciate your understanding of our financial policies. Our goal is to provide high-quality healthcare while making the payment process as clear and manageable as possible. If you have any questions or concerns about this policy, please do not hesitate to contact our office.

Respectfully,

River Oaks Primary Care PLLC

Financial Policy — Patient Acknowledgment

Please sign and return this page to the front desk.

Patient Name (please print)

Date of Birth

I, the undersigned patient, acknowledge that I have read and fully understand the River Oaks Primary Care PLLC Financial Policy and agree to adhere to its terms and conditions.

Patient or Legal Representative Signature

Date