



RIVERSTONE

UROLOGY SPECIALISTS

WELCOME TO RIVERSTONE UROLOGY SPECIALISTS

Thank you for choosing Riverstone Urology Specialists. We are committed to delivering exceptional, evidence-based urologic care with integrity, professionalism, and disciplined clinical excellence.

PRACTICE LOCATION

Address:

24518 Northwest Fwy
Medical Office Building 2, Suite 445
Cypress, TX 77429

Phone: (281) 822-4900

WHAT TO EXPECT AT YOUR VISIT

- Please arrive 15 minutes early for check-in.
- Bring your photo ID, insurance card, and current medication list.
- Some visits may include urine testing, imaging, or lab work.
- Your provider will review findings, treatment options, and next steps before you leave.

YOUR RESPONSIBILITIES

To help us provide the highest level of care, please complete all forms accurately, update us with any changes to your information, bring required referrals, and notify us at least 24 hours in advance if you need to reschedule.

We're honored to care for you.



GENERAL CONSENT FOR TREATMENT AND COMMUNICATION

I voluntarily consent to receive medical care, evaluation, and treatment from the providers and staff of **Riverstone Urology Specialists PLLC**. This may include physical examinations, diagnostic testing, laboratory services, imaging, and routine procedures needed to evaluate or treat my condition. I understand that I may ask questions about any recommended treatment and that I have the right to refuse any service to the extent permitted by law.

I authorize Riverstone Urology Specialists PLLC to obtain medical records, imaging, laboratory results, pathology reports, and other health information from outside providers involved in my care. This includes the electronic exchange of my clinical documents through eClinicalWorks with external connected sites – such as hospitals and other organizations participating in Carequality or similar national health information exchange networks – for treatment and coordination of care. I understand that this exchange operates under an opt-out model. I also authorize Riverstone Urology Specialists PLLC to collect specimens and to send them to outside laboratories or pathology services for analysis as part of my evaluation and treatment.

I understand that medicine is not an exact science and that no guarantees have been made regarding the outcome of my care. I authorize Riverstone Urology Specialists PLLC to release medical information as needed for my treatment, coordination of care, and insurance processing in accordance with applicable privacy laws.

I authorize Riverstone Urology Specialists PLLC to contact me by text message and telephone at the number(s) I provide for appointment reminders, scheduling updates, test result notifications, billing communications, and other messages related to my care. I understand that text messaging and voicemail may not be secure and may carry some risk of unauthorized access, that message and data rates may apply, and that my consent to receive text messages or phone calls is not a condition of receiving care or treatment. This consent remains valid until I revoke it in writing.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



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AUDIO RECORDING CONSENT FOR CLINICAL DOCUMENTATION

I understand that **Riverstone Urology Specialists PLLC** uses audio recording technology to assist with clinical documentation of my visit. I consent to the audio recording of my encounter for the purpose of creating an accurate medical record. I understand that the recording is used only to support documentation and is not retained after the medical note is completed.

I may decline or revoke this consent at any time, and doing so will not affect my ability to receive care. If I choose not to consent, my provider will document the visit using traditional methods.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



NOTICE OF PRIVACY PRACTICES

Riverstone Urology Specialists PLLC Effective February 2026

This Notice describes how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.

1. OUR COMMITMENT TO YOUR PRIVACY

Riverstone Urology Specialists PLLC is committed to protecting your health information. We create a medical record of the care and services you receive. We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice

2. HOW WE MAY USE AND SHARE YOUR HEALTH INFORMATION

We may use or disclose your PHI for the following purposes without your written permission:

Treatment: To provide, coordinate, or manage your medical care. Examples include sharing information with your referring physician, pharmacy, laboratory, imaging center, or other providers involved in your care.

Payment: To bill and receive payment from you, your insurance company, or a third party. Examples include verifying benefits, obtaining prior authorizations, submitting claims, or responding to insurance inquiries.

Healthcare Operations: For practice management, quality improvement, training, auditing, and compliance. Examples include reviewing provider performance, improving services, or conducting internal audits.

Appointment Reminders & Care Notifications: We may contact you by phone, voicemail, text message, mail, or patient portal for appointment reminders, test result notifications, billing updates, and care coordination. You may request alternative communication methods at any time.

3. BUSINESS ASSOCIATES

We may share your health information with business associates who assist us in providing services. These may include billing companies, laboratories, IT vendors, transcription services, and other contracted partners.

All business associates are required by law and contract to protect your information and use it only for the services they provide to us.

4. OTHER USES AND DISCLOSURES ALLOWED OR REQUIRED BY LAW

We may also use or disclose your PHI without your authorization when required by federal or Texas law, including:

- Public health reporting
- Abuse, neglect, or domestic violence reporting
- Health oversight activities
- Judicial or administrative proceedings
- Law enforcement purposes
- Organ and tissue donation
- Workers' compensation
- Serious threats to health or safety
- Specialized government functions (military, national security, etc.)

5. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN PERMISSION

We will not use or disclose your PHI for the following unless you give us written authorization:

- Marketing communications
- Sale of your health information
- Most uses of psychotherapy notes
- Release of information to family or friends (unless you provide written consent)

You may revoke your authorization at any time in writing.

6. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights under HIPAA and Texas law:

Right to Access: You may request to see or obtain a copy of your medical record. We will provide it within the time required by law. You may also access portions of your medical record electronically through our patient portal.

Right to Request Corrections: If you believe your record is incorrect or incomplete, you may request an amendment.

Right to Request Restrictions: You may ask us to limit how we use or share your PHI. We are not required to agree, except when you pay in full for a service and request that we not bill your insurance.

Right to Confidential Communications: You may request in writing that we contact you in a specific way (e.g., at a different phone number or address).

Right to an Accounting of Disclosures: You may request a list of certain disclosures we made without your authorization.

Right to a Paper Copy of This Notice: You may request a paper copy at any time, even if you received it electronically.

7. TEXAS-SPECIFIC PRIVACY PROTECTIONS

Texas law provides additional protections for certain types of information, including:

- Mental health records
- Communicable disease information
- Genetic testing results
- Substance use treatment information

These records will not be released without your written authorization unless required by law.

8. OUR RESPONSIBILITIES

We are required to:

- Maintain the privacy of your PHI
- Notify you if a breach occurs that may have compromised your information
- Follow the terms of this Notice
- Provide updates if our privacy practices change

9. CHANGES TO THIS NOTICE

We may change this Notice at any time. The updated Notice will apply to all PHI we maintain and will be posted in our office and on our website.

10. QUESTIONS OR COMPLAINTS

If you have questions or believe your privacy rights have been violated, you may contact:

Privacy Officer: Lindsey Wallace

Phone: (281) 822-4900

Address:

Riverstone Urology Specialists PLLC
17515 Spring Cypress Road, Suite C-304
Cypress, TX 77429

You may also file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

11. Acknowledgment of Receipt

You will be asked to sign a separate form acknowledging that you received this Notice.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed the Notice of Privacy Practices for **Riverstone Urology Specialists PLLC**. This Notice explains how my medical information may be used and disclosed, and how I may access this information.

I understand that:

- Riverstone Urology Specialists PLLC may use and disclose my health information for treatment, payment, and healthcare operations as described in the Notice.
- I have the right to request restrictions, request confidential communications, access my medical record, request amendments, and obtain an accounting of disclosures.
- I may request a paper or electronic copy of the Notice at any time.
- This acknowledgment only confirms receipt of the Notice and does not change any of my rights under HIPAA or Texas law.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



RIVERSTONE
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NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Date of Birth: _____ Sex Assigned at Birth: Male Female

Social Security Number: _____ Driver's License #: _____ State: _____

Marital Status: Single Married Divorced Widowed

Preferred Language: _____ Interpreter Needed: Yes No

Preferred Contact Method: Phone Text Email

May we leave voicemail? Yes No

Race (select one):

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Decline to Answer |

Ethnicity (select one):

- | | |
|--|--|
| <input type="checkbox"/> Hispanic/Latino | |
| <input type="checkbox"/> Not Hispanic/Latino | <input type="checkbox"/> Decline to Answer |

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Member ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance

Insurance Company: _____

Member ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Primary Care Physician (PCP)

Do you have a PCP? Yes No PCP Name: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone Number: _____

How did you hear about us? _____

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



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AUTHORIZATION TO RELEASE INFORMATION

I authorize **Riverstone Urology Specialists PLLC** to verbally discuss my health information with the individuals listed below. This may include information related to my condition, symptoms, test results, medications, billing, and scheduling.

Authorized Contact #1

Name: _____

Relationship to Patient: _____ Phone Number: _____

Authorized Contact #2

Name: _____

Relationship to Patient: _____ Phone Number: _____

I understand that this authorization remains in effect until I revoke it in writing. I acknowledge that any revocation will not apply to disclosures already made in reliance on this authorization.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____
Signature of Minor Individual DATE

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.



PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

Thank you for the opportunity to provide your urologic care. We are committed to ensuring your comfort, safety, and satisfaction.

The purpose of this disclosure is to inform you that the physicians at **Riverstone Urology Specialists PLLC** may have a financial interest in the following facilities, companies, or entities:

- Memorial Hermann The Woodlands Surgery Center
- HCA Willis Surgery Center
- Grand Cypress Imaging and Advanced Diagnostics

You may be referred to one or more of these facilities or providers for services at any time as part of your recommended care plan. You have the legal right to choose where you receive all medical, surgical, diagnostic, imaging, and laboratory services. If you prefer to use an alternate facility or provider, please inform your physician or a member of our staff, and we will accommodate your request whenever possible. Your decision will not affect the quality of care you receive or your relationship with your physician.

If you have any questions about this notice or would like additional information, please feel free to ask your physician.

PATIENT ACKNOWLEDGEMENT

By signing below, you acknowledge that you have read and understand this Physician Disclosure of Financial Interest.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



FINANCIAL POLICY

We at **Riverstone Urology Specialists PLLC** are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy. Thank you for choosing us for your healthcare needs.

TO ASSIST US IN ESTABLISHING YOUR FINANCIAL ACCOUNT, PLEASE:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information, and demographic information.
- Pay all insurance co-payments, deductibles, co-insurance, and non-covered services on the day services are rendered.

REGARDING INSURANCE

- Insurance is a contract between you and your insurance company. We are not a party to that contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or “reasonable and customary” charges other than to supply factual information as necessary. You are responsible for timely payment of your account.
- If you are scheduled for surgery, you are responsible for paying your estimated portion no less than 48 hours prior to your surgery date.
- Any payments made to Riverstone Urology Specialists PLLC are for physician services only. Payments do not include charges from facilities, anesthesia providers, assistant surgeons, laboratories, or pathology services. These entities bill separately. Many procedures performed in our office require specimens to be sent to an outside laboratory or pathology vendor, and you will be billed separately for those services. You are responsible for any charges billed by these outside providers.
- Each time you make an appointment with a Riverstone Urology Specialists PLLC physician, it is your responsibility to ensure that the provider is currently contracted with your managed care plan. Verification of your coverage and benefits may be required. This verification may require us to share the reason for your visit with your insurance plan. Please present your current insurance card at each visit.
- If you are referred by your Primary Care Physician, it is your responsibility to ensure that a valid referral has been completed if required by your insurance. You must track expiration dates and the number of visits authorized. Most managed care plans do not allow retroactive referrals, so this must be completed before your date of service.
- If your insurance company deems a service “non-covered,” you understand that you are personally responsible for payment.

- Riverstone Urology Specialists PLLC has a \$25 no-show fee for appointments not canceled or rescheduled at least 24 hours in advance. This fee is not billable to insurance.
- If your insurance does not cover a prescribed medication and/or requires a prior authorization, the office requires a \$25 prior authorization fee before processing. This fee does not guarantee insurance approval. As an alternative, you may contact your insurance company to request a covered alternative, which the provider will prescribe if clinically appropriate.
- FMLA, Short-Term Disability, Cancer Policy forms, or any other forms requiring completion by staff or physicians are subject to a \$25 form fee.

ADDITIONAL FINANCIAL POLICIES

Credit Card on File

Riverstone Urology Specialists PLLC requires a valid credit card to be kept on file for any patient responsibility remaining after your insurance company processes your claim. Your card will only be charged after we receive the Explanation of Benefits (EOB) from your insurance carrier indicating your financial responsibility.

Returned Check / Failed Payment Fee

A \$25 fee will be charged for any returned check or failed electronic payment. This fee is the patient's responsibility and is not billable to insurance.

Refund Policy

Refunds for overpayments will be issued after all claims related to the date of service have been fully processed by your insurance company. Refunds will be issued to the original form of payment whenever possible.

Self-Pay / No Insurance Patients

Patients without active insurance coverage are responsible for payment in full at the time of service. Estimates may be provided upon request, but final charges may vary based on services rendered.

Out-of-Network Insurance Plans

If Riverstone Urology Specialists PLLC is out-of-network with your insurance plan, you will be responsible for all charges not covered by your plan. It is your responsibility to verify whether Riverstone Urology Specialists PLLC is in-network with your insurance prior to your appointment.

DISCLOSURE OF OWNERSHIP

Please be advised that Riverstone Urology Specialists PLLC is a physician-owned group, and one or more providers may have a financial interest in a surgery center, laboratory, or other entity where you may receive treatment. Providers may schedule your services at an entity in which they hold ownership. You have the right to choose where you receive your medical and surgical services. Please inform the physician or staff if you prefer to receive services at an alternate facility.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and understand the Riverstone Urology Specialists PLLC Financial Policy and agree to be financially responsible for all charges not covered by my insurance plan.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



ASSIGNMENT OF BENEFITS (AOB)

I understand that I am responsible for charges not covered or reimbursed by my insurance carrier and/or benefits provider at the time of service. I agree, in the event of nonpayment, to assume the costs of interest, collection, and legal action (if required). I authorize my insurance carrier and benefits provider to release information regarding my coverage and claims to Riverstone Urology Specialists PLLC for billing, payment, and healthcare operations.

I assign to Riverstone Urology Specialists PLLC my right to receive payment from my insurance carrier for all services and items provided, including pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing or physician services. This assignment applies to all benefits under Medicare, other government-sponsored programs, private insurance, and any other health plans. If my insurance carrier or benefits provider does not permit assignment of benefits, I instruct them to issue benefits checks payable to me and mail them **in care of my name** to:

Riverstone Urology Specialists PLLC
17515 Spring Cypress Road
Suite C - 304
Cypress, TX 77429

I authorize Riverstone Urology Specialists PLLC to pursue administrative appeals and take any necessary action, including ERISA claims, to obtain payment for services rendered. If I receive any payment directly from my insurance carrier or benefits provider for services rendered by Riverstone Urology Specialists PLLC, I agree to endorse and forward such payment immediately. I understand that failure to do so may result in legal action.

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient



RIVERSTONE
UROLOGY SPECIALISTS

CREDIT CARD AUTHORIZATION

I authorize **Riverstone Urology Specialists PLLC** to keep my credit card on file and to charge my card for any patient-responsibility amounts owed, including copays, deductibles, coinsurance, non-covered services, payment plan installments, and any remaining balance after my insurance company processes my claim and issues an Explanation of Benefits (EOB).

I understand that my card information is stored securely through a PCI-compliant processor and that Riverstone Urology Specialists PLLC does not store full card numbers or security codes. I may update or revoke this authorization in writing at any time, and revocation does not apply to charges already incurred.

Printed Name of Patient

Date of Birth (DOB)

Cardholder Name: _____ Last 4 Digits of Card: _____

Billing Address: _____

Signature

Date



PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Preferred Language: _____ Interpreter Needed (YES/NO): _____

1. REASON FOR VISIT

Main reason for today's visit: _____

When did this begin? _____ Has it changed over time (YES/NO): _____

What makes it better or worse? _____

Have you tried any treatments? _____

2. UROLOGICAL SYMPTOMS (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Trouble urinating | <input type="checkbox"/> Nocturia (times per night): _____ |
| <input type="checkbox"/> Weak stream | <input type="checkbox"/> Kidney stone history |
| <input type="checkbox"/> Burning with urination | If yes, last episode: _____ |
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Recurrent UTIs |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Incomplete bladder emptying | <input type="checkbox"/> Testicular or scrotal pain/swelling |
| <input type="checkbox"/> Urine leakage | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Curved penis/erection |
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Other: _____ |

3. SEXUAL AND REPRODUCTIVE HEALTH (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Libido concerns | <input type="checkbox"/> STI history or concerns |
| <input type="checkbox"/> Ejaculatory issues or pain | <input type="checkbox"/> Prior testosterone therapy |
| <input type="checkbox"/> Fertility concerns | |

4. FEMALE PATIENTS (if applicable)

- Stress incontinence
- Urge incontinence
- Pelvic organ prolapse symptoms
- Vaginal estrogen use

Number of pregnancies: _____
Number of births: _____
Menopause (Yes/No): _____

5. PAST MEDICAL HISTORY

Please list any medical conditions you have been diagnosed with: _____

6. SURGICAL HISTORY

Year: _____ Surgery: _____
Year: _____ Surgery: _____
Year: _____ Surgery: _____

7. HOSPITALIZATIONS

Year: _____ Reason: _____
Year: _____ Reason: _____
Year: _____ Reason: _____

8. ALLERGIES

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

9. MEDICATIONS

Medication: _____ Strength: _____ Frequency: _____
Medication: _____ Strength: _____ Frequency: _____
Medication: _____ Strength: _____ Frequency: _____

10. FAMILY HISTORY

Is there any family history of the following diseases? If Yes, please indicate which family member has/had any of the following:

- Adrenal Disease Yes No _____
- Bedwetting Yes No _____
- Bladder Cancer Yes No _____
- Crohn’s Disease Yes No _____
- Diabetes Yes No _____
- Gout Yes No _____
- Heart Attack Yes No _____
- Heart Disease Yes No _____
- Hypertension Yes No _____
- Other: _____
- Kidney Cancer Yes No _____
- Kidney Disease Yes No _____
- Kidney Stones Yes No _____
- Multiple Sclerosis Yes No _____
- Prostate Cancer Yes No _____
- Stroke Yes No _____
- Thyroid Disease Yes No _____
- Tuberculosis Yes N _____

11. SOCIAL HISTORY

Marital status: Single Married Divorced Widowed Number of children: _____

Occupation (or prior occupation): _____

Alcohol use: Yes No If yes, how often? _____

Caffeine use: Yes No If yes, type/how often? _____

Tobacco use: Current smoker — Type/how long/how much? _____

Former smoker — Year quit: _____ Never smoker

Recreational drug use: Yes No If yes, what kind? _____

12. REVIEW OF SYSTEMS (ROS) (check all that apply)

- Fever
- Chills
- Weight loss
- Nausea
- Constipation
- Abdominal pain
- Back pain
- Flank pain
- Weakness
- Numbness

13. PHARMACY INFORMATION

Preferred pharmacy: _____ Pharmacy phone: _____

Signature of Patient

Date

Printed Name of Patient

Date of Birth (DOB)

If signing on behalf of the patient:

Name

Relationship to Patient