NEW PATIENT FORM

Patient Name: DOB: ☐ M ☐ F

Phone Number: SS#:

Address: City: State/Zip:

Email:

Marital Status: ____ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment: ____ Full Time ☐ Part Time ☐ Self ☐ Retired ☐ Military ☐ Unemployed ____ Student

Employer: Work Phone Number:

Insurance

Primary Insurance: Policy #:

Group #:

☐ Check box if same as patient information Relation to patient:

Policy holder's Name: DOB: ☐ M ☐ F

Phone Number: SS#:

Address: City: State/Zip:

☐ Check box if no secondary insurance

Secondary Insurance: Policy #:

Group #: Relation to patient:

Policy holder's Name: DOB: ☐ M ☐ F

Phone Number: SS#:

Address: City: State/Zip:

How would you like to receive notice about payment? ____ Email ☐ Text ☐ Mail

How would you like to receive notice about appointment reminders? ____ Email ☐ Text ☐ Phone Call

How did you hear about us?

_____ Advertisement _____ NICA Infusion Site Locator _____ Drug Website Infusion Site Locator

_____ Provider Name or Clinic (optional): _____

_____ Friend/Relative, Name (optional): _____

Other: _____

HIPAA Privacy Authorization Form & Authorization of Release of Information

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

I authorize Red River Health LLC to use and disclose the protected health information described below to my referring physician and any others necessary for coordination of my care.

This authorization for release of information covers the period of healthcare from (**please check one**):

☐ until consent is revoked in writing **OR** ☐ until the following date (mm/dd/yy): _____

Extent of Authorization (**please check one**):

☐ I authorize the release of my complete health records (including records relating to mental health, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record except for the following information:

- Mental health records
- Alcohol/drug abuse treatment
- Communicable disease (including HIV/AIDS)
- Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claim payment or other purposes as I may direct. This authorization shall be in force and effect unless revoked by the patient or legal representative.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that revocation is not effective to the extent that any person or entity has already acted in reliance or on my authorization or if my authorization with obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Emergency Contact Information:

Name:	Name:
Relation to patient:	Relation to patient:
Phone number:	Phone number:
Email:	Email:

This authorization grants permission to the Emergency Contacts named above to (**please check all that apply**):

☐ Have access to my medical record information and scheduling

☐ Have access to my billing and insurance information

X _____

Patient Name (Print) Patient/Caregiver Signature Date

_____

If signed by caregiver, please print name and provide relation to patient (e.g. parent, spouse, etc.)

PATIENT CONSENT FORM

Clinic Name: Red River Health Ambulatory Infusion Clinic **Date:**	
Patient Name:	**Patient ID:**
Patient Address:	**DOB:**
Patient Phone Number:	**SS#:**

SECTION 1: Consent to Infusion Therapy, Medical Care and Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests, provided by Red River Health Ambulatory Infusion Clinic (the "Infusion Center") and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my noncompliance. I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

_____ [Initials]

SECTION 2: Consent to Treatment in an Open Area

I acknowledge and understand that the Infusion Center provides infusion therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the Infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality of any inadvertently disclosed health information of others.

_____ [Initials]

SECTION 3: Notice of Privacy Practices

Your health information is contained in a medical record that is the physical property of Red River Health. Red River Health uses information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Under the federal HIPAA regulations, you and Red River Health have certain rights and restrictions relating to the uses and disclosures of your information. Among its obligations, Red River Health is required to maintain the privacy of protected health information; provide you notice of its legal duties and privacy practices; notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and obtain to use or disclose your health information for certain defined reasons. THE FULL TEXT OF THE NOTICE OF PRIVACY PRACTICES WAS PROVIDED WITH YOUR NEW PATIENT PAPERWORK. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE PATIENT INFORMATION CAREFULLY.

I have received Red River Health's **Notice of Privacy Practice** and have had it explained to me. _____ [Initials]

I hereby authorize Provider and any other organizations as outlined in the Privacy Notice to review and obtain copies of the patient medical and financial records. These authorizations take effect immediately and a copy is as valid as the original.

SECTION 4: Consent to Use of Information

Electronic Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

_____ [Initials]

PATIENT CONSENT FORM

SECTION 5: Financial Responsibility and Agreement to Pay

I, the Patient or legal guardian who signs the agreement accepts full responsibility for payment of charges incurred for all deductibles, out of pocket requirements, co-payments, coinsurance amounts, products and services not covered by my insurance company or third-party payer unless such liability is expressly waived by state or federal law. If for any reason my insurance carrier or other source of medical coverage does not pay, or Red River Health is not notified in writing 60 days in advance of any change in coverage or eligibility status, I may be liable to pay the usual and customary prices for all products, services, and therapies provided. In the event that Red River Health does not receive payment for products and services provided, I understand that the outstanding balance may be referred to a collection agency and/or an attorney. I agree to pay reasonable attorney's fees and costs of collection for any past due balances for the products and services provided.

_____ [Initials]

SECTION 6: Assignment of Benefits

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Infusion Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization..

_____ [Initials]

SECTION 7: Personal Valuables

I understand that the Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

_____ [Initials]

SECTION 8: Patient Bill of Rights and Responsibilities

I affirm that I have read and understand the patient rights and responsibilities and have received a copy of the patient rights and responsibilities.

_____ [Initials]

SECTION 9: Appointment Lateness and Cancelation Policy

I affirm that I have read and understand the Red River Health's Appointment Lateness and Cancelation Policy and have received a copy of the policy.

_____ [Initials]

SECTION 10: Consent to Communication

I voluntarily consent to receiving calls and messages, including auto-dialed and pre-recorded message calls, and SMS messages (including text messages) from us, our affiliates, marketing partners, and others calling at their request or on their behalf, at any telephone numbers that you have provided or may provide in the future (including any cellular telephone numbers). Your cellular or mobile telephone provider will charge you according to the type of plan you carry.

_____ [Initials]

PATIENT/GUARANTOR AND WITNESS SIGNATURES

I have initialed all applicable sections and agree with and to all initialed sections.

_____		_____	
Patient/Caregiver Signature	Date	Witness Signature	Date

Notice of Privacy Practices
For Red River Health LLC
Effective Date: February 22, 2023

The Infusion Center understands that your health information is sensitive, and we are committed to protecting it. This Notice of Privacy Practices (Notice) describes how your health information may be used and disclosed, and how you can get access to this information. Please review this document carefully.

Your Health Information: The Infusion Center creates a record of your care. Typically, this record contains information such as your symptoms, test results, diagnoses, treatment, and related medical information, as well as billing and insurance information. This Notice applies to all of the records related to your care that the Infusion Center creates or maintains.

How We Use Your Health Information: This Notice describes how we may use within our Infusion Center and disclose your health information. This Notice also describes your rights to access and control your health information.

Uses and Disclosures of Health Information Not Requiring Consent or Authorization: The following categories describe different ways that we use and disclose medical information without your written authorization under most circumstances. While we set forth examples, not every potential use or disclosure in a category will be listed.

Treatment: We will use and disclose your health information to provide you with medical treatment or services. Your health information may be disclosed to physicians, providers, nurses, technicians, interns, and others involved in your care at the Infusion Center. We may also disclose your health information to other healthcare providers outside the Infusion Center who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your health information for payment and collection purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from you, your health plan (e.g. your insurance) and/or applicable third parties. Health information may be shared with the following: billing companies, insurance companies (private and government health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operations: Your health information may be used and disclosed for purposes of furthering day-to-day Infusion Center operations. We may use and disclose your health information for administrative, financial, legal, and quality improvement activities performed to operate the Infusion Center's business and to support our core functions of treatment and payment. For example, we may combine and assess the health information of our patients to evaluate the need for new services or treatment. We may use and disclose your health information to perform various functions (e.g. appointment reminders, accreditation; quality evaluations or records analysis; training staff, students, interns, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the Infusion Center). We may use your health information to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your health information with Business Associates who assist us in performing operational functions, but we will always obtain assurances from them to protect your health information the same as we do.

As Required by Law: We may have an obligation under federal, state, or local law to disclose your health information. For example, we may be required to report gunshot wounds, suspected abuse, or neglect.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

Research: We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Food and Drug Administration (FDA): We may disclose to the FDA medical information related to FDA regulated products or activities to collect or report adverse events, product defects or problems, or biological product deviations, to track FDA-regulated products; to enable product recalls, repairs or replacement, or conduct post marketing surveillance.

Abuse, Neglect, Or Domestic Violence: We may disclose your health information if we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure or disciplinary actions or other government oversight activities. These activities are necessary for the government to monitor the healthcare system, government benefit programs, and compliance with law.

Judicial and Administrative Purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative, and law enforcement purposes.

Health or Safety: We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Law Enforcement Purposes: We may disclose your medical information to law enforcement officials in the following cases: as required by law to report wound or physical injury; in compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, subpoena, summons, or similar process; identification or location of a suspect, fugitive, material witness, or missing person; in limited circumstances when the individual is or may be the victim of a crime; about an individual who has died to alert law enforcement that the individual's death may have resulted from criminal conduct; related to criminal conduct that occurred on the Infusion Center's property; or in a medical emergency not on the Infusion Center's property to report the nature or location of a crime, the victim(s) of such crime, and the identity, description, and location of the criminal.

National Security and Intelligence Activities: We may release your health information to authorized federal officials for lawful intelligence, counterintelligence and other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information to a coroner or medical examiner to identify a deceased person, determine cause of death, or other purposes as authorized by law. We may disclose medical information to funeral directors so they can carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose medical information to organ procurement organizations or other entities engaged in the procurement, storage, or transplantation of organs, eyes, or tissue to facilitate organ, eye, or tissue donation and transplant.

Inmate or in Custody of Law Enforcement: If you are an inmate in a correctional institution or under lawful custody of law enforcement, we may disclose your health information to a correctional institution or law enforcement official as allowed or required by law.

Disaster Relief: We may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts as permitted or required by law.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health: We may disclose your medical information for public health activities, including: for prevention or control of disease, injury, or disability; for reporting of disease, injury, or vital events such as birth or death; for public health surveillance, investigations or interventions; at the direction of a public health authority to an official of a foreign government agency acting in collaboration with a public health authority; to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect; to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition; for reporting of child abuse or neglect; under limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce related to a work-related illness or injury or a workplace-related medical surveillance.

Disclosure to Relatives, Close Friends and Other Caregivers: We may use or disclose your health information to a family member, other relative, a close friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we obtain your agreement or provide you with the opportunity to object to the disclosure and you do not object or if we reasonably infer that you do not object to the disclosure. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval.

Patient Directory Information: Unless you object, we will include your name, location of the facility, and your general condition (good, fair etc.) in our patient directory and make this information available to anyone who asks for you by name.

Certain Limited Marketing Communications: We may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you.

Uses and Disclosures of Health Information Requiring Authorization: For uses and disclosures for purposes other than as described above, we are required to have your written authorization. Most uses and disclosures for marketing purposes (other than under the limited circumstances as described above) and disclosures that constitute the sale of your health information require your authorization. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already relied on your authorization. We will not use or disclose psychotherapy notes about you without your authorization except for use by the mental health professional who created the notes to provide treatment to you or to defend ourselves in a legal action or other proceeding brought by you.

Your Rights Regarding Your Health Information: You have certain rights with regard to your health information as described below.

Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions, we are not required to agree to a requested restriction unless the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which you have paid us out of pocket in full. If you wish to request additional restrictions, please contact the Privacy Officer. We will send you a written response.

Right to Receive Communications by Alternative Means/Locations: You may request in writing, and we will attempt to accommodate any reasonable request, to receive your health information by alternative means of communication or at alternative locations.

Right to Inspect and Copy Your Health Information: You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may

deny you access to a portion of your records. If you desire access to your records, please submit a written request to the Privacy Officer. If you request copies, we may charge you a reasonable copy fee as permitted by law. Right to

Request Amendment to Your Record: You have the right to request that we amend your health information maintained in your record. If you desire to amend your record, please submit the request in writing to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of certain disclosures of your health information made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a 12- month period, we may charge you a reasonable fee for the accounting statement.

Right to Receive Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.

Further Information; Complaints: If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your health information, you may contact the Privacy Officer. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington DC, 20201.
We will not retaliate against you if you file a complaint.

Breach of Unsecured Health Information: You have the right to receive notification of any breach of your unsecured health information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice at the Infusion Center. You can also request a copy of our Notice at any time. If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer.

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

Welcome to Red River Health Ambulatory Infusion Clinic. Your therapy will be provided by experienced professionals in the comfort of our infusion suite. It is our goal to provide you with the best care possible and to provide an affordable alternative to hospital or home-based care. We believe that all patients receiving services from Red River Health should be informed of their rights.

Patient Rights

- You have the right to exercise your rights as a patient of Red River Health.
- Your family or guardian may exercise your rights if you have been judged incompetent.
- You have the right to have your property treated with respect.
- You have the right to voice grievances regarding your treatment or care that is or may fail to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of Red River Health and must not be subjected to discrimination or reprisal for doing so.
- Red River Health will investigate your (or your family's) complaints and will document both the existence of the complaint and the resolution of the complaint.
- You have the right to be informed in advance of who will be providing and is responsible for your care, and the frequency of your proposed visits/treatments at our center.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know what support services are available, including whether or not an interpreter is available if you do not speak English.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to confidentiality of your clinical records maintained by this agency. Information from your clinical record will not be released without your consent unless required by law.

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

Patient Responsibilities:

- The patient should recognize a Medical Emergency and call proper support if a medical emergency occurs. The patient should not wait for infusion center staff to respond.
- The patient is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- The patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- The patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- The patient is responsible for following the treatment plan recommended by the healthcare provider.
- The patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- The patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
- The patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct and is expected to treat the staff with dignity and respect.
- The patient is responsible for keeping appointments and when he or she is unable to do so for any reason, for notifying the healthcare provider or health care facility.
- The patient is responsible for notifying Red River Health of any changes, or potential changes, to the insurance.
- The patient is responsible for notifying the office if the patient is going to be 15 minutes or more late and the patient recognizes that the office may or may not be able to keep the patient’s current appointment and the patient may need to reschedule the appointment.

GRIEVANCE/COMPLAINT REPORTING

You may submit a grievance/complaint (verbal or written) without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance/complaint, please call (903) 792-9124 and speak to the Red River Health Compliance Officer.

A complaint investigation will be initiated within 10 days after receipt of complaint. You will be given a verbal or written response within 14 days. If your complaint is not resolved to your satisfaction, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days of receipt.

You may also make inquiries or complaints about this clinic by the following options:

Medicare:

Phone: 1-800-MEDICARE

Health and Human Services:

Phone: 1-800-458-9858

Mail: Secretary of the U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington DC, 20201

Texas Medical Board:

Phone: 1-800-201-9353

Online: https://www.tmb.state.tx.us/page/place-a-complaint

Mail: Texas Medical Board
George H.W. Bush State Office Building
1801 Congress Avenue, Suite 9.200
Austin, TX 78701

Texas State Board of Nursing:

Phone: (512) 305-7431

Online: https://txbn.boardsofnursing.org/complaint

Mail: Texas Board of Nursing, Enforcement
1801 Congress Avenue, Suite 10-200
Austin, TX 78701

Appointment Lateness and Cancelation Policy

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancelation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 20 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancelations. Red River Health's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24-48 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "Appointment Lateness & Cancelation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. **Established patients:**

a) Appointment must be canceled at least 24 hours prior to the scheduled appointment time.

b) In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the Clinician on the same day, they will be rescheduled for a future visit.

c) In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancelations," the patient may be subject to transfer of care from Red River Health. The patient's chart is reviewed, and the transfer of care is determined by our Director of Business only, no exceptions.

III. **New patients:**

a) Appointment must be canceled at least 24 hours prior to the scheduled appointment time.

b) In the event of a "no-show", Red River Health will notify the referring provider to inform them of your missed treatment.

c) In the event a patient arrives late as defined by "late arrival" to their appointment, the servicing provider will need to determine if the patient needs to reschedule their appointment based on the patient schedule for the day and types of treatment. Red River Health reserves the right to cancel your appointment as it will impact the schedule for the remainder of the day.

d) In the event of three (3) documented "same-day cancelations," the patient may be subject to transfer of care from Red Rive Health. The patient's chart is reviewed, and transfer of care is determined by our Director of Business only, no exceptions.