1038 Early Blvd., Early, Texas 76802 | Phone: 325-646-4800 | Fax: 325-646-4806
Email: bioenve1038@yahoo.com | Website: www.bioenve.com

Name:	DOB:
Home Address:	City/State/Zip:
Phone Number: Home/Cell:	Email: *(email correspondence is not considered to be confidential)*
Social Security Number: Sex: Male | Female	Race: Declined American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Race Ethnicity: Declined Hispanic or Latino Not Hispanic/ Latino
Height: Weight: Age:	Marital Status: Married Single Divorced Domestic Partner Widowed
Employer:	Occupation:
Emergency Contact:	Emergency Contact Relationship/Phone Number:
Primary Care Physician:	Pharmacy:

Insurance Health Information (Primary Carrier) *A copy of your insurance card is required.

Insured's Name: (Primary Policy Holder)	Insured's DOB:
Insurance Company:	Insurance Company Address:
Insured's Employer:	Insured's Social Security Number:
Insurance ID Number:	Insurance Group Number:

Secondary Health Information; if applicable. *A copy of your insurance card is required.

Insured's Name: (Primacy Policy Holder)	Insured's DOB:
Insurance Company:	Insurance Company Address:
Insured's Employer:	Insured's Social Security Number:
Insurance ID Number:	Insurance Group Number:

Medical History: (Please check and/or list pertinent medical history)

- ❑ Anxiety
- ❑ Atrial fibrillation
- ❑ Arrhythmia
- ❑ Blood clot
- ❑ Pulmonary embolism
- ❑ Cancer: _____
- ❑ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ❑ Covid-19 Covid-19 Vaccine(s): ___Pfizer ___Moderna ___Johnson & Johnson

  Date of Injection(s): _____ _____

- ❑ Depression
- ❑ Diabetes
- ❑ Gerd
- ❑ Hemochromatosis
- ❑ High Blood Pressure/Hypertension
- ❑ High cholesterol/Hyperlipidemia
- ❑ HIV or any type of hepatitis
- ❑ Stroke and/or heart attack
- ❑ Thyroid Issues: Hypothyroidism | Hyperthyroidism | Goiter
- ❑ Other: _____

_____

Surgical History: _____

_____

_____

Family History: (Please check pertinent family history)

Medical Issue	**Family Relationship**	**Maternal or Paternal**
❑ Heart Disease	_____	_____
❑ Diabetes	_____	_____
❑ Osteoporosis	_____	_____
❑ Alzheimer's/dementia	_____	_____
❑ Breast Cancer	_____	_____

❑ Other: _____

_____

Screening History:

Date of Screening:	**History of abnormal findings?**	
Last Pap Smear:	Yes, specify:	NO
Last Mammogram:	Yes, specify:	NO
Last Colonoscopy:	Yes, specify:	NO
Last Bone Density:	Yes, specify:	NO

OB History: (Please circle)

None Hysterectomy Tubal Ligation Vasectomy Birth control pills Infertility Abstinence

IUD: Brand: _____ Expiration Date: _____

Date of last period: _____/_____/_____

Total Pregnancies:	Full term: _____ Miscarriages: _____ Premature: _____ Ectopic: _____ Multiple births: _____ Living: _____

Gynecological History: (Check all that apply)

- ❑ STD
- ❑ Urinary Tract Infections
- ❑ Problems with Bowel Movements
- ❑ Irregular or heavy periods
- ❑ Menopause
- ❑ Ovarian Cysts
- ❑ Infertility
- ❑ PCOS
- ❑ Endometriosis
- ❑ Uterine fibroids
- ❑ Menstrual migraines
- ❑ Sexually active

Social History: (Please check pertinent social history)

- ❑ I have never smoked (non-smoker).
- ❑ I am a former smoker and smoke _____per day.
- ❑ I currently smoke cigarettes or cigars _____per day.
- ❑ I currently use e-cigarettes _____a day.
- ❑ I currently vape _____ x's per day.
- ❑ I use caffeine _____a day.
- ❑ I drink alcoholic beverages _____per week.
- ❑ I drink more than 10 alcoholic beverages a week.
- ❑ I exercise _____times a week.
- ❑ I do not exercise.

Drug and/or other known allergies:

- ❑ No known allergy
- ❑ No known drug allergy
- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Latex
- ❑ Other: _____

Please list all medications AND dosage you are currently taking.

Medication Name:	Dosage AND Instructions:

Hormone Replacement History:

Are you currently on hormone replacement therapy? _____ Yes _____ No

If yes, what? _____

Past hormone replacement therapy? _____ Yes _____ No

If yes, what? _____

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HORMONE REPLACEMENT FEE ACKNOWLEDGEMENT AND INSURANCE DISCLAIMER

Bio-Identical hormone replacement is a unique practice and is considered a form of alternative medicine. Although many board-certified medical providers offer bio-identical hormone replacement therapy to their patients, in most cases, insurance companies do not recognize it as a medical necessity.

BioEnve is not contracted with any insurance company. BioEnve will not contact any insurance company directly or indirectly to seek prior-authorization, benefit details or reimbursement for the bio-identical pellets and/or supplements.

Payment will be required at the time of service. Upon request, we will gladly provide a detailed receipt if you wish to seek insurance reimbursement directly. WE WILL NOT, however, communicate in any way with insurance companies.

This form and payment will serve as evidence of your out-of-pocket payment made, and your decision to proceed with the bio-identical hormone replacement treatment and/or to purchase recommended supplements.

For Health Savings account holders, you may choose to pay for bio-identical pellets and/or supplements with your health savings credit/debit card. Some of these accounts require that you pay in full ahead of time, and request reimbursement later with a receipt and letter. However, please be aware that your insurance company HSA account may seek reimbursement from you if it is determined not to be an eligible benefit through your plan.

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding of, and agreement with, the above terms. I also understand that I am responsible for all charges with BioEnve.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Stefanie McCain, MD

BioEnve

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Servies. www.hhs.gov

We have adopted the following polices:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, ect. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of our protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

BioEnve

Stefanie McCain, MD

Dear Patient:

Physicians have always protected the confidentiality of our patient's health information by securing medical records away from open access and refusing to reveal information. Additionally, State and Federal laws set security standards to ensure the confidentiality of this sensitive information.

The federal government published regulations designed to protect the privacy of your health information. The "Privacy Rule" protects health information that is maintained by hospital, health care providers, and health plans. Physicians, as of April 12, 2003, must comply with the federal government's regulations privacy rule's standard for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription, or send a claim, your health care provider will need to comply with the privacy rules. All health precautions in our office to safeguard your health information, such as training our employees and employing computer security measures.

The privacy rule also provides your certain rights, such as the right to have access to your medical records. However, they are exceptions. We also take precautions in our office to safeguard your health information. We request that you take the time to review the privacy practices of the office before you see the medical providers.

You may request, from the receptionist, a copy of the NOTICED of PRIVACY PRACTICES, to take with you for further review. Federal regulations require that we document that the patient has been advised of our privacy practices and offered a copy of the notice. Additionally, we must receive documentation of the patient's authorization for communication. We require that you complete the attached form to serve as the formal documentation for both the notice and consent for communication. If you have any questions regarding our privacy practices, you may schedule a meeting with the privacy officer for further details and review.

Thank you for your patience and assistance.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document. Furthermore, by my specific initials, I authorize my physician and his/her staff to contact me by the designated means noted below.

_____home phone/answering machine/voicemail _____office/workplace/voicemail

_____cell phone/text _____fax

I authorize my physician and his/her staff to communicate information regarding my appointment, medical results, and billing issues to:

_____spouse_____ _____other_____

_____other_____ _____other_____

This Authorization shall remain in force until revoked in writing, attention of Privacy Officer.

_____ _____ _____

Signature of Patient or Personal Representative Printed Name Date

BioEnve

Stefanie McCain, MD

Check In- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Questionnaire. This will avoid delays in creating your chart and account at your visit. Please arrive at least 10 minutes prior to your scheduled time so that all information can be verified.

Missed Appointments, Late Cancellation, Late Arrivals, and Non-Compliance- We require a 24-hour advance notice, you must cancel or reschedule your appointment. We offer patient reminder calls, texts and/or emails prior to your appointment which will allow you to cancel or reschedule. However, it is ultimately your responsibility to keep track of your appointment whether you receive a reminder or not. **Cancellations made with less than the required 24-hour advanced notice will be charged a $25 late cancellation no-show fee,** and patients with multiple cancellations or missed appointments may be discarded from our practice.

***Please note** that non-compliance with treatment plans including medication and/or lab work and abusive/inappropriate behavior towards staff and/or patients will result in immediate dismissal of your care from our practice.

Nurse Practitioners/ Physician Assistants- Dr. McCain has Nurse Practitioner(s) and/or Physician Assistant(s) to assist in the delivery of medical care. All medical providers are advanced practice providers who have completed a graduate level education and training in the diagnosis and management of medical conditions.

Forms of Payment- We accept payment in the form of cash, debit and/or credit cards. Checks are no longer accepted as a form of payment due to the high volume of returned checks. If an approval is given to you to pay by check, if the check is returned as non-sufficient or for any other reasons, you will be charged an additional $35 fee.

Please note** that there is a ***3.5% service charge fee when paying by debit, credit or any Health Savings debit/credit card.

Collection Fees-All office visit charges are due at the time of service. This will include any co-pays or co-insurance amounts. If for some reason it is not collected at the time of service or if the insurance company does not pay the expected amount, a statement will be sent, and the balance will be due upon receipt of the statement. We will send a maximum of 3 statements, then your account will be turned over to a collection agency.

I have read, understand and agree to the above office and financial polices of Stefanie McCain, MD. I hereby attest that I have been given and agree to provide current demographic and insurance information and authorize release of information necessary to insurance filing by signing this statement. My signature below states my agreement and understanding of Stephanie McCain, MD's office and financial policies and serves as a request and consent for treatment. I authorize and assign all benefits to be made directly to Stefanie McCain, MD.

Signature of Patient/Legal Representative_____ Date_____

Printed Name of Patient/Legal Representative_____Date_____