



Name:	DOB:
Home Address:	City/State/Zip:
Phone Number: Home/Cell:	Email: <i>(email correspondence is not considered to be confidential)</i>
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
- Pulmonary embolism
- Cancer: Breast Endometrial Cervical Ovarian Thyroid Cancer Meningioma
Other: _____
- Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- Covid-19 Covid-19 Vaccine(s): ___Pfizer ___Moderna ___Johnson & Johnson
Date of Injection(s): _____
- Depression
- Diabetes ___Type 1 ___Type 2
- Gerd
- Hemochromatosis
- High Blood Pressure/Hypertension
- High cholesterol/Hyperlipidemia
- HIV or any type of hepatitis
- Epilepsy or Seizure Disorder
- Stroke: If yes, when: _____
- Heart Disease/Heart attack: If yes, when: _____
- DVT/Blood Clot: If yes, when: _____
- Sleep apnea
- Thyroid Issues: Hypothyroidism | Hyperthyroidism | Goiter | Hashimoto's | Graves' Disease
- Rheumatoid Arthritis
- Multiple Sclerosis
- Systemic Lupus
- Psoriasis
- IBS
- Crohn's Disease
- Ulcerative Colitis
- Kidney Disease: If yes, when: _____
- Lymphangiomyomatosis
- Osteoporosis or Osteopenia
- Other: _____

Surgical History: _____

Family History: (Please check pertinent family history)

Medical Issue	Family Relationship	Maternal or Paternal
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Alzheimer's/dementia	_____	_____
<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> 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: _____ Are you currently trying to conceive? Yes No					

Gynecological History: (Check all that apply)

- STD
- Urinary Tract Infections
- Problems with Bowel Movements
- Irregular or heavy periods
- Menopause
- Ovarian Cysts
- Polyps or History of Endometrial Polyps
- Fibrocystic Breast Disease
- Infertility
- PCOS
- Endometriosis
- Uterine fibroids
- Menstrual migraines
- Pre-Menstrual Syndrome
- History of endometrial ablation
- Sexually active

Social History: (Please check pertinent social history)

- I have never smoked (non-smoker).
- I am a former smoker and smoked _____ 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:

<input type="checkbox"/> No known allergy <input type="checkbox"/> No known drug allergy <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Latex <input type="checkbox"/> 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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1038 Early Blvd., Early, Texas 76802

Phone: 325-646-4800

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: _____



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 Services. www.hhs.gov

We have adopted the following policies:

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 several 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 on the use of our protected health information and to request change in certain policies used within the office concerning your 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.



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 hospitals, 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

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 policies 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 _____



Stefanie McCain, MD

Disclaimer for Patient SureScripts Medication History

BioEnve / Stefanie McCain, MD Brownwood, PA, utilizes SureScripts to verify and ensure the accuracy of your medication list. This service is designed to enhance patient safety and support informed healthcare decisions.

I acknowledge that by signing this form below I consent to and agree that BioEnve/Stefanie McCain, MD Brownwood, PA and any affiliated entities and healthcare providers will request, access, and receive my medication history data from Surescripts to confirm my prescribed medications. 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.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____



Stefanie McCain, MD

1038 Early Blvd., Early, Texas 76802

Name:	Date of Birth:
Phone Number:	Street Address:
City:	Zip:
Emergency Contact:	Phone Number:

GENERAL VITAMIN/MINERAL/AMINO ACID INJECTABLES INFORMED CONSENT

Super Slim Shot-(Pyridoxine HCL, Methionine, Inositol, Choline Chloride, Thiamine HCL, Riboflavin (B2)

Tri-Immune Boost (Glutathione, Ascorbic Acid, Zinc Sulfate)

Injection common side effects include; but are not limited to:

1. Risks: I understand there is risk of mild diarrhea, upset stomach, nausea, a feeling of irritation/warmth at site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain.
2. I understand that although rare, these injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking these injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of these injections and such side effects should be reported to a physician or walk in urgent care immediately for evaluation.

Rare, but possible side effects include:

- **Rapid heartbeat/chest pain/tightness**
- **Difficulty breathing and swallowing/shortness of breath**
- **Dizziness/confusion**
- **Hives, skin rashes**
- **Fever/chills**
- **Abnormal bleeding**
- **Metallic taste**
- **Kidney damage**
- **Stomach ulcers**
- **Wheezing**
- **Abdominal cramps**
- **Insomnia**
- **Acid Reflux**

I understand **I should not take** vitamin/mineral/amino acid injections if **any of the following conditions apply to me:**

1. Pregnant or breastfeeding
2. Individuals with kidney or liver disease
3. People with a history of heart disease or high blood pressure
4. Individuals with allergies or sensitivities to the ingredients: Some people may have allergies or sensitivities to the substances present in Super Slim and/or Tri-Immune injections. If you have known allergies or sensitivities to any of the above-mentioned ingredients, it is best to avoid these injections.
5. Those on certain medications: Lipo Mino injections (Super Slim) and/or Tri-Immune Boost injections can interact with certain medications, such as blood thinners or medications for diabetes or high blood pressure.

By signing below, I acknowledge that I have read this informed consent and agree to the injections, and that none of the listed possible contraindications mentioned above apply to me. I am aware that other unforeseeable complications could occur. I have been informed of the possible effects that the Injectables may have, the importance of discussing with my primary medical provider about possible contraindications prior to receiving injection(s) and the importance of notifying my doctor of such use. I give consent to perform this and any subsequent injections. I also understand that if I am a female and become pregnant or start nursing, it is my responsibility to make the facility aware of the change in status. I hereby release the medical providers, the person injecting the injection and the facility from all liability associated with this procedure.

Patient Signature: _____

Date: _____

Printed Name: _____

Stefanie McCain, MD



LABS THROUGH INSURANCE OR PRE-PAID?

As you consider your hormone labs, **you have a choice**. Our goal is to help you make a well-informed decision. No matter which you choose, please note, the labs we are ordering are considered medically necessary based on your symptoms, and to help manage and improve your health and wellness. **The amount you pay when labs are processed through your insurance depends on a few factors:**

1) Insurance Contracts and Deductibles: a. Your insurance carrier may have negotiated lab cost with specific laboratories such as: LabCorp, Quest etc. Regardless of the "billed rate," you may receive the benefit of the "contracted rate." b. If no such agreements are in place, your labs are considered "out of network." While some insurance plans provide some level of "out of network" benefits you will more than likely encounter a higher "patient responsibility" bill/co-pay. c. At the beginning of the new calendar year, or if you have not met your plan deductible, your "patient responsibility" bill/co-pay may be higher, or you may be responsible for the full amount.

2) Cash Options: a. We offer you the option to pre-pay your labs through BioEnve/Stefanie McCain, MD. We have negotiated a discounted rate for cash pay clients. This option was created for our patients to avoid surprises and to help those who currently do not have insurance. Please note, your insurance company could potentially have a more favorable rate for the lab panel than the cash price of our office. b. If you have a Health Saving Account (HSA) or Flex Savings Account (FSA), you can use it to pay the cash price, and we can provide you with a receipt for submission to your HSA or FSA upon request. 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.

After careful consideration I am electing the following option for all lab draws through the office of BioEnve/Stefanie McCain, MD. If I desire to **change the selected billing option** for any further lab work, I understand that **it will be MY responsibility to notify BioEnve/Stefanie McCain, MD** prior to lab draw.

Insurance Billed: Please submit my labs through my insurance company. I **understand** that any amount not paid by my insurance company to the lab filing my claim **will be my responsibility** and I **will receive a bill directly from the lab**. BioEnve/Stefanie McCain, MD will not contact the lab or any insurance company directly or indirectly to seek prior-authorization, benefit details or reimbursement for lab work. I understand that I cannot change the billing option after the lab work has been drawn or receive billing statement from lab for amount that went towards "patient responsibility" after insurance has processed my claim.

Pre-paid: I prefer to pre-pay (self-pay) my lab tests through BioEnve/Stefanie McCain, MD.

Printed Name _____ Signature _____ Date _____

Female BHRT Checklist

Name: _____ Date: _____ DOB: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe	Very Severe
Fatigue					
Mood Changes					
Decreased Mental Ability					
Excessive Sweating					
Hot Flashes					
Night Sweats					
Decreased Sex Drive					
Sleep Problems					
Cold hands and feet					
Hair Loss/ Breakage					
Dry and wrinkled skin					
Breast Tenderness					
Migraines/severe headaches					
Difficult to climax sexually					
Bloating					
Vaginal dryness					
Difficulty with sexual intercourse					
Swelling all over the body					
Joint Pain					
Bladder problems (difficulty urinating, increased need to urinate, incontinence)					

Other Medical Symptom History:

- History of Breast Cancer
 Epilepsy or Seizures
 Endometriosis or History of Endometriosis
 Fibrocystic Breast Disease
 PCOS
 History of Leiomyoma or Endometrial Polyps
 Acne
 Hashimoto's Thyroiditis
 Facial Hair
 Pre-Menstrual Migraines
 Breast Tenderness/Pain

Other symptoms or unique health circumstances to take into consideration: _____
