1038 Early Blvd., Early, Texas 76802 | Phone: 325-646-4800 | Fax: 325-646-4806

Email: bioenve1038@yahoo.com | Website: www.bioenve.com

Name:	DOB: Sex: Female | Male
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
- ❑ 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: _____________________________
- ❑ Lymphangioleimyomatosis
- ❑ Osteoporosis or Osteopenia
- ❑ 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: _______ 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:

- ❑ 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? ____

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: ______________________________

____

____

Insurance Billing & Patient Financial Responsibility Disclaimer

Medical Consultations** Medical consultations and related office services are provided through **Stefanie McCain, MD** and billed to insurance when applicable. Any copays, deductibles, coinsurance, or patient-responsible amounts are due at the time of service. Patients may choose to use an HSA or flexible spending card for applicable charges; coverage or reimbursement is not guaranteed. Patients without insurance or services not billable to insurance will be billed directly. Insurance coverage and payment are determined by the patient's insurance plan, and the clinic cannot guarantee coverage or alter coding to obtain insurance payment.

Laboratory Services** Laboratory testing may be ordered as part of the medical evaluation. Laboratory services are processed through an outside laboratory, which files claims directly with insurance. The laboratory will bill the patient directly for any portion that the insurance company determines to be the patient's responsibility. The clinic does not determine laboratory coverage, does not know what charges may be billed, and cannot modify or make changes to laboratory charges.

Elective Treatments & Self-Pay Services** Certain elective treatments, programs, and specialty testing are provided through **BioEnve** and are not billed to insurance. These may include, but are not limited to: * Hormone pellet therapy (bioidentical, considered alternative medicine; most insurance companies do not recognize as medically necessary; BioEnve not contracted with insurance) * Hormone injections * Compounded medications * Medical weight loss programs * GLP-1 therapies * MRT food sensitivity testing * Other wellness or optimization treatments

Elective services, treatments and self-pay testing are the patient's financial responsibility, and payment is due at the time of service. Patients may choose to use an HSA or flexible spending card for these services; coverage or reimbursement is not guaranteed, and the clinic will not seek prior authorization, verify benefits, or submit claims for reimbursement for hormone pellets or any other elective service or treatment.

Medical Evaluation** All consultations include a comprehensive review of your medical history, symptoms, and laboratory results by a licensed provider. This evaluation is designed to determine whether any treatments or therapies are medically appropriate for your individual health needs. Recommendations made during the consultation are based on clinical judgment and medical necessity. Elective services and treatments, including hormone pellets, weight loss programs, and other self-pay therapies, are optional and separate from standard medical care. Patients are encouraged to ask questions, review potential risks and benefits, and discuss alternative treatment options before making any decisions. The provider will advise on safety, appropriateness, and expected outcomes, but the patient is ultimately responsible for decisions regarding elective services and associated financial obligations.

****Key Patient Acknowledgments** *(Please initial each line to acknowledge understanding)***

[ ] I understand that medical consultations are provided through **Stefanie McCain, MD**, billed to insurance when applicable, and that any copays, deductibles, coinsurance, or patient-responsible amounts are due at the time of service. I may choose to use an HSA or flexible spending card for applicable charges; coverage or reimbursement is not guaranteed.

[ ] I understand that laboratory testing is processed through an outside laboratory that files claims directly with insurance and will bill me for any balance my insurance determines to be my responsibility. The clinic does not determine or modify laboratory charges.

[ ] I understand that certain elective services and specialty testing are provided through **BioEnve** and are self-pay, including hormone therapy services, weight loss programs, compounded medications, GLP-1 therapies, and MRT testing. I may choose to use an HSA or flexible spending card for these services; coverage or reimbursement is not guaranteed, and the clinic does not file insurance claims and will not seek prior authorization, benefit verification, or reimbursement for any elective service or treatment, including hormone pellets.

****Patient Acknowledgment / Signature****

Patient Name: ______________________________ Date: ____________________

Patient Signature: ______________________________

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 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.

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 to be 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 de lays 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.

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 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____________________

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: ________________________

Name:	Date of Birth:

GENERAL VITAMIN/MINERAL/AMINO ACID INJECTABLES INFORMED CONSENT

(Pyridoxine HCL, Methionine, Inositol, Choline Chloride, Thiamine HCL, Riboflavin (B2)
B6, Methionine, Inositol, Choline, B1, B2, Carnitine) (Glutathione, Zinc, Vitamin C)

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

1. Risks: I understand there is a 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. Uncommon side effects include:
   - **Rapid heartbeat/chest pain/tightness**
   - **Difficulty breathing and swallowing/shortness of breath**
   - **Dizziness/confusion**
   - **Hives, skin rashes**
   - **Fever/chills**
   - **Abnormal bleeding**

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 shots, such as methionine, inositol, choline, or vitamin B12. If you have known allergies or sensitivities to any of these ingredients, it is best to avoid these shots.
5. Those on certain medications: Lipo Mino shots (Super Slim shot) 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 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 injection and ALL selected subsequent Injections. 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: ______________________

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___________

Medical Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to BioEnve/ Stefanie McCain MD, Brownwood-PA. When you schedule an appointment with our office, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and **no later than 24 hours prior** to your scheduled appointment. This gives us time to schedule other patients who are on our waiting list for an appointment.

Policy Terms & Fees

Due to the increase of no-show/late cancellations, and to help us to continue to provide the best possible service and availability to all our patients, we are adjusting our no-show and late-cancellation fee to **$40**, effective January 01,2026. The following policy applies to all patients and all appointment types, including telehealth appointments:

- **First No Show/Late Cancellation:** Any established patient who fails to show or cancels/reschedules without at least a 24-hour notice will automatically be charged a **$40.00 fee**.
- **Second No Show/Late Cancellation:** Any established patient who fails to show or cancels/reschedules with no 24-hour notice a second time will automatically be charged a **$60.00 fee**.
- **Third No Show/Late Cancellation:** If a third, no show or cancellation/reschedule occurs without 24-hour notice, the patient may be dismissed from our office.
- **New Patients:** Any new patients who fail to show for their initial visit will not be rescheduled, without paying a no-show fee of $50. No-show fee will have to be collected at the time of the initial consultation along with the patient allowable/copay.

Payment Information

- **Direct Charge:** The fee is charged to the patient, not to the insurance company.
- **Payment Due Date:** Fees are due at the time of the patient's next office visit, or prior to rescheduling; when applicable.
- **Collections:** Failure to make the payment will result in the account being sent to collections and could result in dismissal from the practice.

Reminders & Contact Information

- As a courtesy, we make reminder calls, texts, and emails for appointments. However; if you do not receive a reminder, the above policy remains in effect.
- **Phone:** 325-646-4800
- **Email:** bioenve1038@yahoo.com

Telehealth Informed Consent Form

Patient Name: ______________________________ **Date of Birth:** ______________________

1. Nature of Telehealth Services: I understand that "telehealth" includes the delivery of healthcare services, diagnosis, consultation, and treatment using interactive audio, video, or data communications. I understand that the office of Dr. Stefanie McCain, Brownwood PA/BioEnve will determine if my condition is appropriate for a telehealth encounter or if an in-person visit is required to meet the medical standard of care.

2. Patient Rights & Acknowledgments: Standard of Care: I understand that the same standard of care applies to a telehealth visit as an in-person visit in the State of Texas.

- **Voluntary Participation:** I have the right to withhold or withdraw my consent at any time without affecting my right to future care or treatment.
- **Privacy & Security:** I understand that federal and state laws protecting the confidentiality of my medical information (HIPAA) also apply to telehealth. All telehealth sessions at this practice are conducted via secure, encrypted platforms.
- **Right to Information:** I have the right to access all medical information resulting from the telehealth service as provided by law.

3. Risks and Limitations: I understand there are potential risks unique to telehealth, including:

- **Technical Failures:** Interruptions, unauthorized access, or technical difficulties may occur. If the provider cannot reach you around the scheduled start time, it will be considered a "No-Show" and the no-show fee will apply.
- **Clinical Limitations:** The provider may not be able to perform a complete physical exam, which could affect the diagnosis or treatment.
- **Alternative Care:** If a technical failure occurs or telehealth is deemed insufficient, I may be required to schedule an in-person visit.

4. Financial Responsibility

- **Insurance Coverage:** I understand that insurance coverage for telehealth varies by plan. I am responsible for verifying my benefits.
- **Patient Responsibility:** I am responsible for any co-payments, coinsurance, deductibles, allowable, and/or no-show/late cancellation fees that applies to this visit.
- **Billing:** My health information will be shared with my insurance carrier for reimbursement and quality review purposes.
-

5. Emergency Protocol: I understand that telehealth is **not** for emergencies. In the event of an urgent medical crisis, I agree to call **911** or go to the nearest emergency room.

By signing below, I attest that I have read this form (or had it explained to me), understand the risks and benefits of telehealth, and voluntarily consent to receive care via telehealth from any of the medical providers at Stefanie McCain, MD Brownwood, PA/BioEnve office.

Signature of Patient/Guardian: ______________________________ **Date:** ______________

Print Name: ______________________________ **Relationship:** ______________