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.

☐ **Self-pay / cash-pay** (check if you will not be using insurance; leave the insurance sections blank)

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: (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:**

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: _____
- ☐ Lymphangioleiomyomatosis
- ☐ 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 check all that apply)

☐ 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	○	○	○	○	○
Difficulty climaxing 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 is 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 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, etc. 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 your protected health information and to request changes 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.**

BioEnve

STEFANIE McCAIN, MD

BROWNWOOD - PA

PATIENT PRIVACY, COMMUNICATION & RECORDS AUTHORIZATION

Dear Patient:

Physicians have always protected the confidentiality of patients' health information by securing medical records from unauthorized access and refusing to reveal information without appropriate authorization. State and federal laws also establish standards to protect the privacy and security of this sensitive information.

The federal Privacy Rule protects health information maintained by hospitals, health care providers, and health plans. Our office complies with applicable privacy requirements and takes reasonable safeguards to protect your health information, including employee training and appropriate computer and record security measures.

The Privacy Rule also provides you with certain rights, including the right to access your medical records, subject to applicable exceptions. Please review this office's Notice of Privacy Practices before seeing your medical provider. You may request a copy from the receptionist at any time.

Federal regulations require us to document that you have been advised of our privacy practices and to document your authorization for certain communications. Please complete the sections below. Questions may be directed to the Privacy Officer.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information may be used and disclosed, and that I am entitled to receive a copy upon request.

AUTHORIZED METHODS OF COMMUNICATION

By placing my initials below, I authorize the physician and staff to contact me by the designated method(s):

_____ Home phone / answering machine / voicemail

_____ Office / workplace / voicemail

_____ Cell phone / text

_____ Fax

AUTHORIZED PERSON(S) FOR COMMUNICATION

I authorize my physician and staff to communicate information regarding my appointments, medical results, billing issues, and other health care matters with the person(s) listed below:

1. Name: _____ Relationship: _____

Phone: _____

2. Name: _____ Relationship: _____

Phone: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS UPON DEATH

In the event of my death, I authorize this office to release my medical records and protected health information to the individual designated below, to the extent permitted by applicable federal and state law. This designation documents my preference and does not override any legal requirement governing disclosure of a deceased patient's records.

Primary Authorized Person

Full Name: _____

Relationship: _____ Phone: _____

Address: _____

City/State/ZIP: _____

Alternate Authorized Person (optional)

Full Name: _____

Relationship: _____ Phone: _____

Address: _____

City/State/ZIP: _____

This authorization remains in effect until changed or revoked by me in writing during my lifetime, subject to applicable law.

_____	_____	_____
Signature of Patient or Personal Representative	Printed Name	Date

Office & Financial Policies

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 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.

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 cash, debit cards, credit cards, and Health Savings Account cards. Checks are not accepted. If approval is given to pay by check and the check is returned for insufficient funds or for any other reason, a $35 returned-check fee will apply.

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 Stefanie 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 and of 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 Savings Account (HSA) or Flexible Spending 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's 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 received a billing statement from the lab for the amount that went toward "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 by Stefanie McCain, MD. 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

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____