NO SHOW POLICY

I understand that if I need to change or cancel an appointment, a 24-hour notice is required as there are often other patients waiting for appointments. I understand that I will be charged a $25.00 fee if I fail to keep an appointment without calling to cancel or reschedule within an advanced 24 hours unless in case of illness or emergency. This missed visit will be considered a “No Show” and the $25.00 no show fee will be my responsibility. My insurance will not be billed.

AUTHORIZATION OF MEDICAL INFORMATION RELEASE

I authorize Transformation Therapeutics, PLLC to furnish my insurance company with medical information they may request regarding my condition or treatment. I also authorize Transformation Therapeutics, PLLC to communicate to my referring healthcare provider regarding any medical information needed for treatment. Furthermore, I authorize my referring healthcare provider to release any diagnostic reports and/or surgery reports to Transformation Therapeutics, PLLC.

MODE OF CONTACT

Transformation Therapeutics, PLLC can _ leave a voicemail _ send a text message _ speak in person only _ send an email (check all that apply)

PRIVACY NOTICE AND PATIENT BILL OF RIGHTS

I have read and understand Transformation Therapeutics, PLLC Privacy Notice and Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian of the patient named below.

Patient signature_____

Date_____