Identification Document

1. Name:_____ Date of Birth:_____

   Street Address:_____ Apt./Unit #:_____

   City:_____ State:_____ Zip Code:_____

   Who referred you?_____

   What goals do you hope to achieve with Thrivewell? _____

2. Phone:_____ Email: _____ Skype Username: _____

   State:_____Occupation: _____

   Signature:

   _____ _____

   Signature: Date

3. **Please attach a photo copy of your driver's license or state id below. Use your phone camera please, or if you're uploading from a computer make sure it is a jpeg or png file. We cannot accept pdfs or docx files here.**

Health History

Patient Information

4. Patient's Information

Name: _____ Date of Birth: _____

Height: _____ Weight: _____

5. Please check the following that apply to you.

☐Alcohol Use	☐ Asthma/COPD	☐ Benign Prostatic Hyperplasia
☐ Cancer	☐ Cardiovascular Disease	☐ Depression
☐ Diabetes Mellitus	☐ Erectile Dysfunction	☐ High Blood Pressure
☐ High Cholesterol or Lipids	☐ Insomnia	☐ Sleep Apnea
☐ Osteoporosis	☐ Tobacco Use	☐ N/A

Other:

_____

6. Medical Condition/Diseases Please check all that apply to you

☐ Heart Disease (Ex. CHF)	☐ High Cholesterol or Lipids	☐ Arthritis or joint Problems
	☐ Lung Condition (Ex.Asthma,	
☐ Ulcers (stomach, esophagus)	Emphysema, COPD)	☐ Blood Clotting Problems
☐ Hormone Related Issues	☐ Thyroid Disease	☐ Headaches/Migraines
☐ High Blood Pressure (Ex:		
Hypertension)	☐ Cancer	☐ Depression
☐ Epilepsy	☐ Eye Disease	

Other:

_____

Medication History

7. **If you do not take any medications:**

   Check N/A if Not Applicable:

   ☐ N/A

8. **List all prescription and non prescription medications that you re taking. (Including vitamins, herbals and supplements) If this question does not apply to you please move on.**

	Medication:	Dosage:	Frequency:	Reason for Taking:
1				
2				
3				

9. **Drug Allergies:**

	Allergies:
1	
2	
3	

10. **Surgeries/Hospitalizations**

	Why/Date
1	
2	
3	

11. Check Yes or No to the following questions. If yes, indicate if Mild, Moderate or Severe.

	Yes or No	Indicate level:
1. Do you feel more fatigued and/or tired than usual?		
2. Have you noticed a decrease in your muscle mass?		
3. Have you experienced a loss in muscle strength?		
4. Have you experienced an increase in joint and/or muscle pains?		
5. Have you noticed an increase in your waist size?		
6. Do you have trouble losing weight?		
7. Have you experienced a loss in height?		
8. Do you have a decrease in your sex drive?		
9. Have you experienced difficulty in establishing and/or maintaining an erection?		
10. Do you have a decrease in spontaneous early morning erections?		
11. Have you experienced changes in your usual sleep pattern?		
12. Do you feel a decrease in your mental sharpness?		
13. Have you had trouble concentrating?		
14. Do you experience less enjoyment in personal interests and hobbies?		

12. Age: _____ Feels like how old? _____

---

13. Name of Patient: _____ Date of Birth: _____

Gender:

○Male ○ Female

Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

14. Family Physician: _____ Date Consulted: _____

Reason: _____

Treatment and /or Medication Prescribed?

○ Yes ○ No

15. 1. Have you ever consutated any medical practitioner for, or so far as you know ever been treated for:

	Yes	N0
A. Any disorder of eyes. ears, nose or throat, including speech impairment or loss of sight?		
B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hay fever, spitting blood, or persistent hoarseness or coughing?		
C. Any disorder of the heart or blood vessel,. e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins?		
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?		
E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic?		
F. Any brain disorder or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches?		
G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization?		
H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg, hip, or back disorder?		
I. Anything else. e.g.. cancer, cyst or tumor, blood disorder, hypoglycemia. diabetes, glandular condition, e.g.. thyroid, hernia. skin disease or eczema?		

16. 2.Have you ever:

	Yes	No
A. Had a surgical operation?		
B. Been told to have an operation that wasn't performed?		
C. Had any diagnostic procedures, e.g., x-ray, electro-cardiogram?		
D. Lived with someone who has had T.B. in the last 2 years?		
E. Had a weight change in the past year? If yes, reason? (list below)		
F. Had a physical or mental condition that caused you to be deferred, rejected or discharged from the armed forces?		
G. Ever applied for or received any pension or benefits for sickness, disability or accident?		

17. 3. Other than previously stated, as far as you know, have you In the last 5 years:

	Yes	No
A. Had any illness, disease or injury		
B . Been admitted to, or have been advised to enter a hospital or sanitarium, etc?		
C. Consulted any medical practitioner for any reason (including check-ups?)		
D. Any reason to feel you are not in good health?		
E. Are you taking any medication or drugs?		

18. A Family History

Family Record	Age if living:	Condition of health if not "Good" , please give details:	Age at death:	Cause of Death:
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

19.

	Yes	No
Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?		
Do you participate in regular exercise?		

20. If you are into regular exercise, describe:

	Type of Exercise:	Frequency:
1		
2		
3		

21. 7. Smoking Habits:

Do you smoke cigarettes? If yes, packs per day? _____

○ Yes ○ No

If non -smoker, have you ever smoked cigarettes? If yes, for how long? _____

○ Yes ○ No

Packs per day?_____ When did you quit?_____

_____

_____

Signature

22. Surgeries/Hospitalizations (Why and Date):

23. Surgeries/Hospitalizations (Why and Date):

This agreement between _____, and Thrivewell Primary Care, established guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA controlled or scheduled medications. Thrivewell Primary Care and the patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship**.**

The patient accepts and agrees to the following conditions:

1. I understand that the medication(s) I have purchased are prescribed for me based on diagnosis derived from my submitted medical history, lab work, and physical exam. They are to be based exclusively for treatment of these diagnoses.
2. I will immediately report any adverse side effects related to the use of my medication to Thrivewell Primary Care and discontinue use until advised to resume usage.
3. I will safeguard my medications from loss or theft.
4. I will not share, sell, or trade my medication for money, goods, or services.
5. I agree that I will use my medication at the prescribed rate and dosage, and will keep the medications in its respected labeled container.
6. I will not attempt to obtain scheduled HRT medications illegally or from any other health care practitioner without disclosing my current medication usage. I understand that it is against the law to do so.

Patient Full Name	Patient Signature	Date

"OFF LABEL" USE OF HCG

_____ I understand that this therapy includes "off-label" use of the FDA approved medication HCG Human Chorionic Gonadotropin. I understand that this medication is FDA approved for other medical treatment modalities and has not been approved for the purpose of weight loss. ("Off-label" use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them.) "Off label" prescribing is a legal and common practice by physicians in the United States.

STATEMENT FROM THE FDA

_____ I have been notified that since 1975, the FDA has required labeling and advertising of HCG to state: "HCG has not been demonstrated to be an effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."

Patient:_____

Date: _____

_____ _____

Client Signature Date

CONFIDENTIALITY STATEMENT & TERMS

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implement and follow specific strict security protocols and processes. We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

Your privacy is important to us and we use every care to secure your privacy rights. Your Test Results

You and only you receive your test results unless you direct us in writing to forward your results to a medical practitioner or an additional 3rd party.

HIPAA: Health Insurance Portability and Accountability Act

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully. In compliance with the 1996 Congressional act to protect the privacy of patient's protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes: **Treatment:** Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may include but is not limited to: History and physical, progress notes, laboratory reports, X-ray reports, operative reports, consultation reports, drugs and alcohol dependency, mental health notes, HIV AIDS status, hospital discharge reports, hospital DNR, to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient/client's present and future care.

Payment: Information requested by the insurance company, necessary for the processing of claims for payment of services.

Operations: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure. If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint. We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request. PATIENT AUTHORIZATION Thrivewell Primary Care providing the undersigned patient ("Patient"') with medical management, administrative and referral services, Patient acknowledges and agrees to the following terms and conditions contained in this Patient Authorization Agreement ("Agreement"). With this agreement, Patient submits with this agreement an accurately completed Medical History Form ("MHF"). Patient agrees to respond to truthfully, accurately and completely in completing the MHF or any agent completing the form and

acknowledges that failure to provide truthful, accurate and complete information on the MHF could result in inappropriate treatment.

Patient authorizes Thrivewell Primary Care to obtain on my behalf medical laboratories, diagnostic testing, physicians and dispensing pharmacies. In addition, Patient authorizes and instructs Thrivewell Primary Care and physicians referred by Thrivewell Primary Care ("Physicians") and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the MHF, laboratory diagnostic tests, and other information submitted to Thrivewell Primary Care under this agreement. Patient agrees to present a photo Identification upon any blood testing pursuant to a Prescription or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by Thrivewell Primary Care and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or other insurance.

Patient acknowledges and agrees that Thrivewell Primary Care is not responsible for the negligent or intentional acts or omissions of any health care provider or supplier that Patient is referred or for any action or inaction taken by Patient, that the total liability of Thrivewell Primary Care, its officers, directors, employees, agents, and stockholders is limited to the purchase price of any products through Thrivewell Primary Care, Physicians or Pharmacies, and Thrivewell Primary Care and Physicians will not be liable for any direct, indirect, special, incidental, consequential, or punitive damages. During Patient's relationship with Thrivewell Primary Care and Physician, Thrivewell Primary Care and Physician will convey to Patient a range of proprietary business information, including, confidential disclosures and trade secrets business practices and Thrivewell Primary Care customers and suppliers ("Confidential Information"). No matter how received by the Patient during the parties' relationship, Patient agrees that Confidential Information is confidential, proprietary and uniquely valuable to Thrivewell Primary Care and gravely affects the conduct of business of Thrivewell Primary Care LLC and Thrivewell Primary Care's goodwill. Patient agrees not to disclose, divulge or communicate, in any fashion, form, or manner, either directly or indirectly, any Confidential Information or take any action that may result in disclosure of Confidential Information to any third party person, firm, or business. Based on the above-understanding. Patient agrees to release Thrivewell Primary Care, its officers, directors, employees, agents and shareholders, and Physician from any and all liability associated with or arising from the Physician's consultation or from the medical, physical, behavioral or other effects of any medication or treatment that may be ordered, prescribed or purchased as a result of the Physician's consultation.

Patient acknowledges that he/she is responsible for rendering payment for any agreed upon treatment components between patient and Thrivewell Primary Care. Patient understands that restoring and balancing hormones accurately requires follow up blood work and monitoring. These follow-ups may require additional costs for the patient. Failure to submit to required testing and follow-up procedures as determined by the discretion of the physician on staff may result in discontinued treatment until therapy requirements have been received by Thrivewell Primary Care. The patient understands that he/she will not be refunded for any lab orders or appointments once the service is provided, even if he/she does not qualify for treatment as initially intended. The Patient understands that he/she will not receive a refund for any medications once they are dispensed from the pharmacy. Once medications leave the pharmacy, they cannot be returned.

This Agreement shall be governed, construed and enforced in accordance with the laws of the State of Florida, applicable to agreements made and to be made and to be performed entirely within such State, without regard to principles of conflict of laws. Any disputes arising out of, in connection with or with respect to this Agreement, shall be adjudicated in a court of competent jurisdiction sitting in the state of Florida and nowhere else. Patient hereby irrevocably submits to the jurisdiction of such court for the purposes of any suit, civil action or other

proceeding arising out of, in connection with or with respect to this Agreement. In the event of any litigation arising out of this Agreement, the prevailing party shall be entitled to recover all expenses and costs incurred, including reasonable attorneys' fees and legal assistants' fees.

This Agreement contains the entire understanding of the parties and supersedes and merges all prior and contemporaneous agreements and discussions between the parties. Any and all representations or agreements by any agent or representative of either party not contained in this Agreement shall be null, void, and of no effect.

If any provision of this Agreement or the application thereof to any person or circumstances is invalid or unenforceable in any jurisdiction, the remainder hereof, and all application of such provision to such person or circumstances in any other jurisdiction, shall not be effected thereby, and to this end the provisions of this Agreement shall be severable.

Patient covenants and agrees to indemnify, defend, protect, and hold harmless, and Physician and their respective officers, directors, employees, stockholders, assigns, successors, and affiliates ("Indemnified Parties") from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceedings, investigations, demands, judgments, settlement payments, deficiencies, penalties, fines, interest and costs and expenses suffered, sustained, incurred or paid by the indemnified Parties in connection with, resulting from or arising out of, directly or indirectly, Thrivewell Primary Care and/or Physician's rendering medical care services, advice and/or treatment, Patient's failure to disclose all relevant information regarding Patient's medical and physical condition, acts or omissions of Thrivewell Primary Care or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Thrivewell Primary Care or Physician. Patient is aware of potential side effects associated with the above-described treatment, accepts all risks involved in taking medication and will not seek indemnification or damages from the Indemnified Parties there from. The undersigned acknowledges and agrees that the services provided by Thrivewell Primary Care are noncovered, self-pay services in all instances. The undersigned warrants and represents to Thrivewell Primary Care that he/she will not submit any claims or invoices for services furnished by Thrivewell Primary Care or its affiliates to any insurer, payer or claims administrator, or utilize any health savings accounts funds in violation of the rules applicable to such health savings account.

Patient:_____

Date: _____

_____ _____

Client Signature Date

THE NATURE OF TREATMENT

I hereby give my consent to evaluation and treatment by Thrivewell Primary Care staff of the following specified conditions:

☐Andropause or associated symptoms (including potential repletion of testosterone and DHEA, potential lowering of estrogen/estradiol levels)

☐Other hormone imbalances - please specify

☐Thyroid abnormalities

☐Growth hormone abnormalities including decreased or suboptimal IGF-1

☐Decreased or suboptimal vitamin D-3 levels

☐Other - please specify:

☐Nutritional deficiencies (vitamins, minerals, amino acids, etc)

☐Overweight / Obesity

☐Other - please specify:_____

I agree to the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals, and antioxidants and/or drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition, and treatment objectives.

Alternative Treatment Methods and Their General Nature

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bioidentical in nature (synthetics).

I understand the foregoing alternatives and am choosing to consent to the treatment plan prepared for me by Thrivewell Primary Care to address the condition(s) indicated above

The General Nature and Extent of Treatment- Related Risks

I understand that the possible side effects for men on testosterone replacement are acne, persistent erections, unwanted hair growth, increased risk of blood clots, heart attack, stroke, enlargement of the prostate, enlargement of breast tissue, and testicular atrophy (shrinking).

☐I agree / Initial: _____

Safety of Hormone Replacement

Although, in my physician's opinion, the majority of data points toward safety, there remains controversy regarding the correlation between the use of bioidentical hormone therapy and cancer. Recent data demonstrates that natural progesterone and estriol may be protective against breast cancer.

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk, I understand that I may request copies of all relevant studies known to my physician, and that l may discuss them with my physician.

I also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy will cease and those derived from hormone therapy and drugs that alter hormone levels will reverse If the therapy is discontinued.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones prescribed to me. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent hormone testing, as required, to monitor my hormone levels.

I certify that I am under the regular care of another physician for all other medical conditions. I will consult my physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation I may need.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have, concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.

I fully understand the nature and purpose of portions of the mentioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bioidentical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

Consent

I hereby authorize the Thrivewell Primary Care physician to evaluate and treat the conditions I specified above. I understand the physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers, I am competent to sign this Consent to Treat and have done so of my own free will.

Patient:_____

Date: _____

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES & PROTECTED HEALTH INFORMATION (HIPAA)

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities and public health, research and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum, necessary for the purpose of the disclosure. The provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request stating so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosure that is accessible to you.

In the future we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

I have read the above mentioned Notice of Privacy Practices and affix my signature in acknowledgement.

Print name: _____

Effective date of this Notice of Privacy Practices is: _____

_____ _____

Client Signature Date

(1) The **Weight-Loss Consumer Bill of Rights** shall consist of the following provisions:

(A) Warning: rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program.

(**B)** Consult your personal physician before starting any weight-loss program.

(**C)** Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss.

(D) Qualifications of this provider are available upon request.

(E) You have a right to:

(1) Ask questions about the potential health risks of this program and its nutritional content, psychological support and educational components.

(2) Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.

(**3)** Know the actual or estimated duration of the program.

(**4)** Know the name, address, and qualifications of the physician, dietician or nutritionist who has reviewed and approved the weight loss program according to 468.505(1) (i). Florida Statutes.

Thrivewell Primary Care is a licensed non-diagnostic preventative health care provider. Our doctors and medical staff directly prescribe all required tests and review and confirm all test results. We may also perform physical exams, consult with primary physicians, and validate and verify submitted medical information. Patients who are found to have signs and symptoms of a legitimate medical and/or health condition are referred to a medical specialist in that field for diagnosis and treatment in a specialized and monitored program. Thrivewell Primary Care reserves the right to recommend and use internal and/or external medical specialists for any patient and all patient information will be protected under all HIPPA laws and regulations. Thrivewell Primary Care is not an internet pharmacy and does not dispense, ship, or distribute medications from our facilities or web sites. Any and all medication prescribed by our doctors and/or associated medical associates for medical treatment will be dispensed from a US FDA approved pharmacy. Ali patients are required to fulfill and follow all of the medical instructions and procedures prescribed by doctors and contact us Immediately If they have any problems, questions, or concerns, Patients who are found to have submitted fraudulent information will be terminated from any health program offered by Thrivewell Primary Care or any of its affiliates. Any medication prescribed is only for the use of the patient and is not to be transferred, distributed, modified, or used by any other party

Patient:_____

Date: _____

_____ _____

Client Signature Date

CONSENT TO LEAVE MESSAGE

I_____, give Thrivewell Primary Care permission to leave: (mark all that apply)

☐VOICEMAIL - (Enter phone # if you check this box): _____

☐EMAIL - (Enter email if you check this box): _____

☐TEXT - (Enter phone # if you check this box): _____

I give permission for messages to be left concerning: (mark all that apply)

☐LAB RESULTS

☐APPOINTMENTS

☐PRESCRIPTIONS

☐MEDICALTREATMENT

Is there any information you DO NOT want left on voicemail?

I give permission for my relevant medical information to be left with:

Name: _____

DOB: _____

Phone: _____

Name: _____

DOB: _____

Phone: _____

Cancellation/Missed Appointment Policy for Office Appointments

Due to the increased number of missed and/or canceled office appointments, the office has found it necessary to charge a $25.00 fee if 24 hours notice is not given. This will be due prior to rescheduling your appointment.

If there is a secondary occurrence of a missed or canceled appointment (without a 24 hour advance notice) there will be a $50 fee charged prior to rescheduling your appointment.

Acknowledge of Receipt

I acknowledge that I have read and understand Thrivewell Primary Care's cancellation and/or missed procedure policy.

Patient Full Name	Patient Signature	Date