Welcome to TST Health

This intake form must be completed by the patient.

Currently, TST Health can only serve patients with a New Mexico or Virginia mailing address.
Patients must verbally attest they are located in either New Mexico or Virginia during their virtual visit.

If you are unable to come to NM or VA for your visit, you may

find useful resources from Plan C Pills and Mayday Health.

If you need assistance paying for your medication (~$91) or traveling to an eligible TST Health state, e-mail us at support@tsthealth.org.

HOW DOES THIS WORK?

Step 1:

Complete This Patient Registration and Download the Patient Portal App

Android | iPhone

An invitation with portal log-in instructions is waiting in your email inbox.
Don't see it? Check your spam/junk folder.
Don't forget to click "FINISH" when you complete this questionnaire.

Step 2:

Schedule Your Virtual Appointment

Within 48 hours, you will receive a link via your preferred contact method to schedule.
Choose from a Quick Visit (15 minutes) or Comprehensive Visit (40 minutes).
If you don't see an appointment that works for you, contact us at support@tsthealth.org.

Step 3:

Get Your Medications in the Mail

After your virtual visit, we send your prescription to our pharmacy partner.
Within about 24 hours, they will send you an email to check-out.
Get your medications within 1-3 days (Express) or 3-5 days (Standard).

How would you like to be contacted throughout this process?
You have two options: Encrypted Patient Portal or Text Message

CONFIDENTIAL HEALTH SCREENING

This questionnaire will take 5-10 minutes to complete. All information you provide is confidential. It is important that you answer the questions thoroughly so we can provide you with the best care possible.

Do you need these pills for a current pregnancy or for a potential future pregnancy, also known as "advanced provision"?

Chosen Name

Date of Birth

Gender

Pronouns

Race

Are you of Hispanic origin?

Cell Phone Number

Shipping Address

pregnancy and period details

What was the first day of your last period?

How certain are you of this date?

Was your last period normal in length, cramping, and bleeding?

If you had a positive pregnancy test, when was it?

Have you ever had an ectopic (tubal) pregnancy?

If you've already had a pregnancy dating ultrasound,
how far along are you today?

Were you using hormonal birth control when you got pregnant?

Do you currently have an IUD in place?

Have you had any bleeding since your last period?

Have you had any pelvic pain or cramping since your last period?

personal medical history

tubal ligation (tubes tied)
pelvic inflammatory disease
chronic adrenal failure
long-term corticosteroid use
bleeding or clotting disorder
anticoagulant therapy
postpartum hemorrhage
low hemoglobin/hematocrit/iron
blood transfusion
breast lump or mass
blood clot in arm, leg, or lung
cancer, including lobular carcinoma in situ
heart attack or cardiovascular disease
diabetes - type 1 or type 2
high cholesterol
gallbladder, liver, or kidney disease
lupus or seizure disorder

migraines or severe headache?

high blood pressure?

remember, all of your information is confidential. we rely on your honest answers so we can provide you with the best care possible.

list any allergies and your reactions

list all medications, including over-the-counter and prescription, herbs, and supplements

list all recreational drugs, including cannabis and alcohol, frequency of use and route

list any past or current tobacco use, frequency and type, including vapes and various forms of tobacco

list any previous surgeries, approximate dates and outcomes

If you are looking for support to recover from addiction, check out The Satanic Temple's Sober Faction.

family medical history

blood clot in arm, leg, or lung
cardiovascular (heart) disease
high blood pressure

final questions

Free standard FedEx Priority shipping is included.
Receive your package in 3-5 days.

For an additional $25, you can select FedEx Express shipping.
Receive your package in 1-3 days.

Would you like a prescription for birth control?
Learn more about your options here.

How did you hear about us?

what's next?

Review and Sign the Consents Below:

Once you press "Finish", you will receive a link to schedule your virtual appointment in your patient portal. This may take up to 48 hours.

Email us at support@tsthealth.org if you need additional support or have any questions. We are here to help!

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by The Satanic Temple Health ("**Group**"), and the Group's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**").

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
    - asynchronous communications;
    - two-way interactive audio in combination with store-and-forward communications; and/or
    - two-way interactive audio and video interaction;
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;
- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;
- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 8 hours a day, 5 days a week for new patients, or 24 hours a day, 7 days a week for active patients.
- Convenient access to follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by texting 505-207-3369.
- More efficient care evaluation and management. We are available to respond to non-emergent text and email inquiries within 2 business days, business days being Monday through Friday and excluding federal holidays.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT GROUP OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE PROVIDER.**
- Our Providers are an addition to, and not a replacement for, your local primary care provider. Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate one if you do not.
- **Provider's services are limited to telehealth services only.** Provider does not have any in-person clinic locations.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), with the exception of text messaging.

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Group at 575-997-5537 and support@tsthealth.org.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Patient Acknowledgments:

I further acknowledge and understand the following:

1. I have elected to visit with the next available provider from Group, and have been given my Provider’s credentials.

2. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.

3. I may elect to seek services from a medical group with in-person clinics as an alternative to receiving telehealth services.

4. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.

5. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record.

6. Group will take steps to make sure that my health information is not seen by anyone who should not see it. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state. I consent to Group using and disclosing my health information for purposes of my treatment (e.g., prescription information) and care coordination, to receive reimbursement for the services provided to me, and for Group’s health care operations.

7. Dissemination of any patient-identifiable images or information from the telehealth visit to researchers or other educational entities will not occur without my consent unless authorized by state or federal law.

8. There is a risk of technical failures during the telehealth visit beyond the control of Group.

9. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.

10. Persons may be present during the telehealth visit other than my Provider who will be participating in, observing, or listening to my consultation with my Provider (*e.g.*, in order to operate the telehealth technologies). If another person is present during the

telehealth visit, I will be informed of the individual's presence and their role.

11. My Provider will explain my diagnosis and its evidentiary basis, and the risks and benefits of various treatment options.

12. I understand that by creating a treatment plan for me, my Provider has reviewed my medical history and clinical information and, in my Provider's professional assessment, has made the determination that the provider is able to meet the same standard of care as if the health care services were provided in-person when using the selected telehealth technologies, including but not limited to, asynchronous store-and-forward technology.

13. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting Group at: support@tsthealth.org. A copy will be provided to me at reasonable cost of preparation, shipping and delivery.

14. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that I can log into my "Portal" by downloading the Akute Patient Portal app from the Apple App Store or the Google Play Store at any time to access or review my health information. If I need to update my health information, I can contact my care team by emailing support@tsthealth.org.

15. There is no guarantee that I will be issued a prescription and that the decision of whether a prescription is appropriate will be made in the professional judgment of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.

16. There is no guarantee that I will be treated by a Group provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.

☐ **ACCEPT**. By checking this Box, I acknowledge that I have carefully read, understand, and agree to the terms of this "**TELEHEALTH INFORMED CONSENT**" and consent to receive the Services.

PATIENT'S NAME:

____

PATIENT'S SIGNATURE:

____

DATE:

____

This Notice was originally published and effective on February 1, 2023.

The Satanic Temple Health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes The Satanic Temple Health (collectively "we" or "our") may use and disclose your protected health information to carry out treatment, payment or business operations and for other purposes that are permitted or required by law. We will use and disclose your protected health information as permitted by the Health Insurance Portability and Accountability Act ("HIPAA") and this Notice of Privacy Practices.

"Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or condition, treatment or payment for health care services. This Notice also describes your rights to access and control your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by our health care providers, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support our business operations, to obtain payment for your care, and any other use authorized or required by law.

TREATMENT:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a health care provider to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you.

PAYMENT:

Your protected health information may be used to bill or obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services, such as: making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

HEALTH CARE OPERATIONS:

We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, improving quality of care, providing information about treatment alternatives or other health-related benefits and services, developing or maintaining and supporting computer systems, legal services, and conducting audits and compliance programs, including fraud, waste and abuse investigations.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We may use or disclose your protected health information in the following situations without your authorization. These situations include the following uses and disclosures: as required by law; for public health purposes; for health care oversight purposes; for abuse or neglect reporting; pursuant to Food and Drug Administration requirements; in connection with legal proceedings; for law enforcement purposes; to coroners, funeral directors and organ donation agencies; for certain research purposes; for certain criminal activities; for certain military activity and national security purposes; for workers' compensation reporting; relating to certain inmate reporting; and other required uses and disclosures. Under the law, we

must make certain disclosures to you upon your request, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA. State laws may further restrict these disclosures.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless permitted or required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. Your protected health information will not be used for fundraising. If you provide us with an authorization for certain uses and disclosures of your information, you may revoke such authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

You have the right to inspect and copy your protected health information.

You may request access to or an amendment of your protected health information.

You have the right to request a restriction on the use or disclosure of your protected health/personal information. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have the right to request an amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to our statement and we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures of your protected health information that we have made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes.

You have the right to obtain a paper copy of this Notice, upon request, even if you have previously requested its receipt electronically by email.

REVISIONS TO THIS NOTICE:

We reserve the right to revise this Notice and to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted on our website. You then have the right to object or withdraw as provided in this Notice.

BREACH OF HEALTH INFORMATION:

We will notify you if a reportable breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the protected health information involved and contact information for you to ask questions.

COMPLAINTS:

Complaints about this Notice or how we handle your protected health information should be directed to our HIPAA Privacy Officer. If you are not satisfied with the manner in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

We must follow the duties and privacy practices described in this Notice. We will maintain the privacy of your protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please contact us at 575-997-5537 and ask to speak with our HIPAA Privacy Officer, our Clinical Operations Manager.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By clicking and typing your name in the boxes below, you acknowledge that you have received or been given an opportunity to receive The Satanic Temple Health's Notice of Privacy Practices.

☐ I have received or been given an opportunity to receive The Satanic Temple Health's Notice of Privacy Practices.

____ ____________________

Patient Name Date

If you are the personal representative of the Patient, by clicking and typing the names indicated below, you acknowledge on behalf of the Patient that you have received or been given an opportunity to receive The Satanic Temple Health's Notice of Privacy Practices.

☐ I have received or been given an opportunity to receive The Satanic Temple Health's Notice of Privacy Practices on behalf of ___________________________________ [type in the Patient's Name].

____ ____________________

Personal Representative's Name Date

____

State the nature of your relationship with the Patient and describe your authority to act for the Patient.

TST Health:
Medical Abortion Informed Consent

It is important for you to understand the risks, benefits, and alternatives to receiving a medication abortion by mail, including the risks associated with not receiving an ultrasound prior to the abortion. This document explains those risks, benefits, and alternatives.

Please read the following information carefully, let us know if you have any questions, and sign only if you understand and agree to receiving a medication abortion via mail with TST Health.

WHAT IS A MEDICAL ABORTION?

A medical abortion, also known as the abortion pill or medication abortion, is what we call the process of ending a pregnancy by taking 2 medications. As of 2020, medical abortion accounted for more than half of abortions in the United States.

WHAT ARE THE MEDICATIONS?

Mifepristone is the first medication – It starts the abortion process by blocking a hormone in your body that is necessary for a pregnancy to grow. That hormone is called progesterone and without it the pregnancy cannot continue to develop. This medication is a tablet that is swallowed.

Misoprostol is the second medication – This medication opens the cervix and makes the uterus cramp and contract. This cramping empties the uterus and completes the abortion process. This medication is in tablet form and is dissolved in the cheeks or vagina. You will learn more about these options later.

WHEN CAN YOU HAVE A MEDICAL ABORTION?

The medications for a medical abortion can be taken immediately after someone learns that they're pregnant, up to 77 days or 11 weeks gestation.

HOW EFFECTIVE IS IT?

The effectiveness of the medication abortion, or whether the abortion is complete, depends on how far along you are in the pregnancy.

- 8 weeks or less: about 94-98 out of 100 times
- 8-9 weeks: about 94-96 out of 100 times
- 9+ weeks: about 91-93 out of 100 times. Taking a second dose of misoprostol after 9 weeks increases the effectiveness.

WHAT ARE THE BENEFITS?

The abortion pill is a safe and effective way to end a pregnancy. You can complete the process in the privacy of your own home.

WHAT ARE THE SIDE EFFECTS?

We expect side effects to occur. It is part of the medical abortion process. Side effects don't usually last more than several hours and they usually need little or no treatment.

- Cramping — It will be the worst as you are passing the pregnancy, usually within a few hours of taking the second medication. Milder cramps may last a few days.
- Bleeding — It will be heaviest within a few hours after taking the second medication. You may bleed or spot for up to 6 weeks.
- Fever — Having a low temperature (under 100F) is ok.
- Other — Flu-like symptoms such as chills, nausea, vomiting, headache, dizziness, and tiredness can all be okay as long as they are manageable and improve after taking medication. You may also experience back pain and diarrhea.

All of these symptoms are normal, as long as they go away within 24 hours of taking the second medication. If you have concerns, contact us right away.

WHAT ARE THE RISKS OF MEDICAL ABORTION?

As with any medical procedure, there are risks to taking the abortion pill. However, a medication abortion is very safe.

- **The pregnancy may not end.** If this happens, you may be able to take more medicine or have a suction procedure to complete the abortion.

- **The abortion may be incomplete.** This means that some of the pregnancy remains in the uterus. This can lead to infection, heavy bleeding, or both. If the abortion is incomplete, you may need additional testing or other treatment, such as a suction procedure.

- **There may be blood clots in the uterus.** This can cause belly pain and cramping. You may need a suction procedure if this happens.

- **Bleeding may last too long or be too heavy.** This could require treatment with a suction procedure, medication, or a blood transfusion.

- **Your uterus could become infected.** There is a small risk of uterine infection and infections can be treated with antibiotics.

- **You could have an allergic reaction.** Very rarely, some people are allergic to the medications used for the abortion.

- **Death** from medication abortion — this is very rare.

WHAT ARE THE RISKS OF NOT HAVING AN ULTRASOUND?

An ectopic pregnancy, or a pregnancy located outside the uterus and often in the fallopian tubes, happens in 1-2% of pregnancies. An ectopic pregnancy can cause severe bleeding if it is not identified early in a pregnancy. The growing pregnancy may stretch the fallopian tube and eventually burst the tube. This is very rare but may result in death.

Since not having an ultrasound before using the abortion pill may delay identifying an ectopic pregnancy, it's extremely important to follow-up. A follow-up assessment will confirm the abortion pill worked.

If you are unsure of when you had your last period, let us know so we can help you arrange an ultrasound.

WHAT ARE MY OTHER OPTIONS?

If you are pregnant, you have 3 options — abortion, adoption and parenting.
There are 2 ways to have an abortion — the abortion pill or an in-clinic suction procedure.
Let us know if you'd like to discuss these options.

OTHER INFORMATION:

After you take the abortion pills, you need to make sure that it worked. This can be done by taking a urine pregnancy test 5 weeks after you have taken the misoprostol.

Misoprostol can cause serious birth defects if the pregnancy continues.

Many different feelings before and after taking the abortion pill are normal. Most people feel relieved and do not regret their decision. Any and all emotions before, during, and after this experience are valid. If your mood keeps you from doing the things you normally do each day, let us know. We can help!

No promise can be made about the outcome of your abortion. If you do need emergency medical care, you will be responsible for any additional costs.

By signing below, you have read, fully understand this information, and agree to proceed with a medication abortion with TST Health. You can withdraw your consent at any time.

____ __________________

Patient Signature Date

PATIENT AGREEMENT FORM
Mifepristone Tablets, 200mg

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must sign this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my provider's advice about when to take each drug and what to do in an emergency.
2. I understand:
   a. I will take mifepristone on Day 1.
   b. My provider will either give me or prescribe for me the misoprostol tablets, which I will take 24 to 48 hours after I take mifepristone.
3. My healthcare provider has talked with me about the risks, including:
   - heavy bleeding
   - infection
   - ectopic pregnancy (a pregnancy outside the womb)
4. I will contact the clinic/office right away if in the days after treatment I have:
   - a fever of 100.4°F or higher that lasts for more than four hours
   - severe stomach area (abdominal) pain
   - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
   - stomach pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol
5. My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away, my healthcare provider has told me who to call and what to do.
6. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.
7. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
8. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.
9. I have the MEDICATION GUIDE for mifepristone. I will take it with me if I visit an emergency room or a healthcare provider who did not give me mifepristone so that they will understand that I am having a medical abortion with mifepristone.
10. My healthcare provider has answered all my questions.

Patient Signature: ________________ **Patient Name** (print): ________________ **Date:** ____________

The patient signed the PATIENT AGREEMENT in my presence after I counseled the patient and answered all questions. I have given the patient the MEDICATION GUIDE for mifepristone.

Provider's Signature: ________________ **Name of Provider** (print): ________________ **Date:** ____________

After the patient and the provider sign this PATIENT AGREEMENT, give 1 copy to the patient before the patient leaves the office and put 1 copy in the medical record.