



CANCER INSTITUTE

3140 W. Campus Drive
Bay City, MI 48706
(989) 667-2370
(989) 671-9275 fax

WELCOME TO OUR PRACTICE.

We are dedicated to providing our patients the best possible care available. Enclosed please find new patient information and release forms. We ask you complete these forms prior to your visit. If your insurance is an HMO, please contact your primary care physician for a referral prior to your visit.

Your appointment is scheduled on _____ with _____ MD
at _____ am/pm.

If you can't keep your appointment for any reason, please contact our office as soon as possible so that we may reschedule your appointment.

At the time of your appointment you will need:

- **Your insurance card(s)**
- **A list of current medications**
- **Photo identification**

PLEASE NOTE: A 60-90 minute time slot has been set aside for you. If for any reason you are unable to keep this appointment, a 24-hour notice is required or you may be subject to a fee of \$75. Please feel free to contact us at any time with your questions or concerns.