FW CENTER FOR FERTILITY & IVF

980 Raintree Circle, Allen, TX 75013
Phone (214) 383-2600 Fax (214) 383-2601

Patient Information

Patient Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____

May we leave a message if you are not available? At home ☐ Yes ☐ No At work ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____ Phone: _____

Guarantor Information *(List person or insured name responsible for bill if other than patient)*

Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

Last Name, First Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company_____ Effective Date: _____

Insured's Name: _____ Insured's DOB: _____

Policy / ID Number: _____ Group Number: _____

Claims Address & Phone: _____

Secondary Insurance Company_____ Effective Date: _____

Insured's Name: _____ Insured's DOB: _____

Policy / ID Number: _____ Group Number: _____

Claims Address & Phone: _____

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Patient Rights & Responsibilities

Office hours: Office hours are Monday through Friday from 8:00AM-5:00PM. Weekend hours are available as necessary for ongoing treatment.

Late Policy: If you are 15 minutes or later for your appointment you may be asked to reschedule for another day.

Children in the Clinic: DFW Center for Fertility and IVF does not provide supervision for children left unattended in the clinic. For their safety, we recommend that you make other arrangements for their care or that you bring a childcare provider with you when you have your appointments. Attention you may need to provide for your children detracts from time spent with your provider.

Prescription Refills: Urgent refill requests should be brought to our attention during regular office hours. To request a refill you may: 1) call the office at 214-383-2600, 2) log on to your patient portal accessed via our website at www.DFWfertility.com or, 3) ask the pharmacy to fax your request to 214-383-2601.

The desire of DFW Center for Fertility and IVF is to provide you with the best treatment in an efficient, safe and caring manner. Medications may be ordered by your physician to assist you with pain control. The following are the guidelines to our medication policy:

1. Medications should be taken as instructed by your physician.
2. Medications depleted before the prescribed time frame will not be refilled.
3. Medications refill requests after 3:00 pm will be completed the next business day.
4. Medications will not be prescribed for undiagnosed pain.
5. For situations of persistent pain beyond the normal post-injury or post-operative time, you may be referred to a pain management program. From that point the medications will be handled by the pain specialists. In turn they will keep us informed of your progress.

Physician Emergency on Call Policy: For all life-threatening issues, please call 911 or go to the nearest emergency room. For all other urgent questions occurring outside of regular office hours dial (214) 383-2600 and you will transferred to the physician on call. Our practice provides our patients with direct access to our providers after-hours at no charge. In return, we ask our patients to reserve this service for **only truly urgent matters** that cannot wait until the next business day.

Copying of Medical Records: Patients requesting copies of their medical records will be assessed a $25 fee for the first 20 pages and thereafter $0.50 per additional page. If an affidavit is requested, certifying that the information is a true and correct copy of the records, a reasonable fee of up to $15 may be charged for executing the affidavit. There is no charge to send medical records to your referring OBGYN or continuing care provider. An authorization for release of the information must be signed and submitted before any request for records will be processed.

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Form Completion: Please be aware that we need 7-10 business days to complete forms. There is no charge for completing FMLA papers.

Cancellation and No Show Policy: We understand that all of our patients' time is valuable. So, help us help you by keeping your scheduled appointments. Patients who do not cancel or reschedule their appointments 24 hours in advance may be subject to a fee of $37.00. Our office will make reasonable attempts to confirm appointments in compliance with the above policy. Exceptions will be made for medical or family emergencies. Please note that insurance companies cannot be billed for the missed sessions and you will be required to pay out of pocket.

Patient Termination Policy: Although it is an infrequent occurrence, a patient may be terminated from the office. Patient termination is at the discretion of the patients' provider. Common reasons for the termination include, but are not limited to, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior of staff, physicians, visitors or other patients.

Patient Portal: eIVF offers patients personalized and secure online access to portions of their medical records. It enables you to securely use the internet to help manage and receive information about your health.

To Login to your eIVF Patient Portal:

1. Go to www.dfwfertility.com
2. Click on the "Patient Portal" tab on the upper right hand side of the page
3. Make sure you have your eIVF user ID and password (provided by staff at the time you create your first appointment)
4. Fill in all required fields (please complete past medical history before initial visit)

I have read, understand, and agree to the information and policies set forth in the Patient Rights & Responsibilities.

_____ _____

Print Name Patient Signature

_____

Date

I acknowledge that I have seen or been provided a copy of DFW Center for Fertility & IVF's "Notice of Privacy Practices".

_____ _____

Print Name Patient Signature

_____

Date

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Electronic Communication Guidelines & Consent

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services such as AOL, Yahoo and Hotmail are not secure. This means that email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purpose without your permission.

Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider my route your email messages to other members of the staff for information purpose for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency you should call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team.

_____ _____

Print Name Approved E-mail Address

_____ _____

Patient Signature Date

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Patient Consent to Treatment

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather to make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request DFW CENTER FOR FERTILITY & IVF, as my physician, and such associates, assistants, nurses and other healthcare providers as it may deem necessary or advisable, to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at DFW CENTER FOR FERTILITY & IVF. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my condition outcome may be affected. During the course of the treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associate apprised of any changes in my medical condition. Certain diagnostic test, treatment, and drug therapies can be dangerous under certain medical conditions or medication use.

By signing this consent form you are agreeing that DFW CENTER FOR FERTILITY & IVF, can request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provided informed consent to DFW CENTER FOR FERTILITY & IVF, for treatment. I will have the chance to ask questions and all of my questions have been answered to my satisfaction.

I understand that no warranty or guarantee will be made to me as to result of any drug therapy, treatment of cure of my condition. I will have the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment(s) or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, medical treatment(s) and or diagnostic procedure(s), I believe I have sufficient information to give this informed consent. I hereby consent to treatment and medication history inquires.

_____ _____

Print Name Patient Signature

_____

Date

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Financial Policy Form

Non-covered Services: A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full for all charges.

Payment: While knowing your insurance plan and how it pays is ultimately your responsibility, our office attempts to verify all patient's insurance benefits prior to their appointment. Any copay, deductible, or co-insurance is due at time of service. We will give you the best estimate possible based off of the benefits quoted. Please keep in mind, sometimes benefits are misquoted by your insurance carrier; however we must collect based off their explanation. Once your insurance carrier has finalized your claim, we will make any necessary adjustments to your account. All outstanding balances are due in full upon receipt of statement. Payment can be in the form of Cash, Credit Card or Secured Funds. We do not accept personal and/or business checks. Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued.

Claims Filing: While we are not obligated to file claims for you with all contracted insurance companies, we are happy to do so as a courtesy to our patients. We will file deductible and co-insurance amounts to any secondary insurance (except Tricare or Medicare) you provide us; co-payments will not be filed to your secondary.

Insurance Billing and Payment: It is sometimes necessary for our billing department to appeal claims. In doing so, it may also be necessary to involve other agencies such as the Texas Medical Association and/or the Texas Department of Insurance. Please be assured we will only release information that is absolutely necessary.

Referrals/Authorizations: Should your insurance company require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment.

Labs: Any specimens (i.e. blood work) that are sent to an outside lab will be billed by the appropriate lab. We do our best to forward the most current insurance information we have on file with each specimen. Should you receive a bill from the lab due to incorrect information simply call the lab and provide your current insurance information.

I have read, understand, and agree to the information and policies set forth in Financial Policy Form.

_____ _____

Print Name Patient Signature

_____

Date

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Authorization Form to Release Protected Health Information to Spouse/Partner/Other

This authorization grants permission to my Spouse / Partner / Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and fertility treatment plans; and have access to my financial health information.

I hereby authorize DFW Center for Fertility and IVF to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / partner, or the party named below, the released information may no longer be protected by the federal privacy regulations.

_____ _____
Patient Name Date of Birth

_____ _____
Spouse / Partner / Other Relationship to Patient

_____
Address City State Zip

_____
Spouse / Partner / Other Address (if different from patient)

_____ _____
Patient Phone Spouse / Partner / Other Phone

The patient must read and understand the following statements:

1. I understand that this authorization will be effective for the lifetime of the patient unless revoked.

2. I understand that I may revoke this authorization at any time by notifying DFW Center for Fertility and IVF in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by DFW Center for Fertility and IVF prior to their receipt of the revocation.

3. I understand that I have the right to refuse to sign this authorization and that my treatment cannot be conditioned on whether I sign.

_____ _____
Patient Signature Date

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Authorization to Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I hereby authorize and request (physician you would like DFWCFI to receive records from):

Dr. Name / Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

To release the following information to:

DFW Center for Fertility and IVF
980 Raintree Circle, Allen, TX 75013
Phone: 214-383-2600 Fax: 214-383-2601

Please Check One:

☐ Entire Medical Record

☐ Initial Fertility Evaluation and Relevant Fertility Testing Results

☐ Other: _____

Reason for Disclosure:

☐ Treatment / Continued Medical Care

☐ Other: _____

This signed release is valid for 120 days from the date of signature; however you may cancel / remove this authorization any time prior to that date by submitting a written request.

_____ _____

Patient Signature Date

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Patient Referral Source

We are pleased that you are now a patient at DFW Center for Fertility & IVF. We hope that your experience with our office will go above and beyond your expectations. Please let us know whom to thank for your referral.

How did you hear about our practice? ***(Please check all that apply)***

- ☐ Another Physician/Provider _____
- ☐ Friend/Family – Word of Mouth
- ☐ Insurance Company
- ☐ Location
- ☐ Phone Book
- ☐ Event
- ☐ Magazine
- ☐ Newspaper
- ☐ Other advertisement, where _____
- ☐ Practice printed material
- ☐ Web Search
- ☐ Practice Website
- ☐ Other _____