

Welcome to DFW Center for Fertility & IVF!

Thank you for choosing our practice to partner with you during your fertility journey.

Your new patient consultation will be scheduled once we have received all of the required information below and verified your insurance benefits (if applicable).

We will collect your estimated responsibility at the time of scheduling.

The following is required from **both** the patient and their partner (if applicable):

- Review our Privacy Policy by visiting our website www.dfwfertility.com
- Log into your patient portal. (Refer to the email for your user id and password.)
- Upload the completed New Patient paperwork (1/per person – pdf format).
- Upload a front/back copy of your driver's license & insurance card.
- Upload a picture of just your face (for your chart).
- Complete the Medical History Questionnaire.

If you have any questions or difficulty accessing the patient portal, please contact our office at 214-383-2600.

Patient Registration Information

Patient Name: _____ Date of Birth: ____/____/____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Marital Status: ☐ Single ☐ Married
Social Security Number: ____-____-____ Sex: ☐ Male ☐ Female
Email address: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse or Partner Information

Relationship to Patient: Spouse _____ Partner _____
Patient Name: _____ Date of Birth: ____/____/____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Marital Status: ☐ Single ☐ Married
Social Security Number: ____-____-____ Sex: ☐ Male ☐ Female
Email address: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance Policy

Carrier Name: _____
Policy Holder's Name: _____ Date of Birth: ____/____/____
Policy / ID Number: _____ Group Number: _____
Claims Address: _____ Phone Number: _____

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

Referral Source: ☐ Friend/Family: _____ ☐ Insurance ☐ Event ☐ Magazine/Newspaper
☐ Social Media ☐ Another Provider: _____ ☐ Other: _____

I authorize the release of any medical information necessary to process a claim to my insurance carrier. I hereby assign all medical insurance benefits to which I am entitled to DFW Center for Fertility & IVF. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original.

Printed Name of Patient

Signature of Patient

Date

Patient Rights & Responsibilities

Office hours: Office hours are Monday through Friday from 8:00AM-4:30PM. Weekend hours are available as necessary for ongoing treatment.

Late Arrival, Late Cancellation & No Show Policy: If you are 15 or more minutes late for your appointment you may be asked to reschedule for another time and/or day. We understand that all of our patient's 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 **\$100.00**. Please note that insurance companies cannot be billed for the late cancellation or no show fee. Our office will make reasonable attempts to confirm appointments.

Visitors in the Clinic: Children are not allowed in the office. We remain sensitive to all of our patient's infertility struggles, therefore we ask that you make child care arrangements. The majority of our services are not appropriate for a child and our staff are not available for childcare. Your visits require your full undivided attention.

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

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

Copying of Medical Records: Patients requesting copies of their medical records in a paper format will be assessed a \$25 fee for the first 20 pages and \$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. Please be aware that we may need up to 15 business days to complete this request.

Form Completion: Please be aware that we need up to 7-10 business days to complete forms. There will be a \$25 charge for completing FMLA paperwork.

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 patient's provider. Common reasons for the termination include, but are not limited to, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior towards staff, physicians, visitors or other patients, etc.

Right to Good Faith Estimate: For non-covered, cash only services, you have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, laboratory tests, and equipment fees. If you schedule a health care item or service at least 3 business days in advance, make sure your healthcare provider gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any healthcare provider for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider gives you a Good Faith Estimate in writing within 3 business days after you ask. If you receive a bill that is at least \$400 or more for any provider than your Good Faith Estimate from that provider, you can dispute the bill. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

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

Printed Name of Patient

Patient Signature

Date

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 the patient's 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. Patient payments for new patient appointments are due at the time of scheduling. We will give patients the best estimate possible based off of the benefits quoted. Please keep in mind, sometimes benefits are misquoted by insurance carriers; however, we must collect based off of the explanation of benefits. 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.

Nonpayment: If your account is over ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and your account will be subject to finance charges.

Claims Filing: It is the patient's responsibility to confirm in-network status for their specific plan/group with both our office as well as their insurance company. We will file insurance claims for *eligible* covered services ONLY. We will not file claims for non-covered/non-billable services. Payment is due at the time the non-covered service is rendered, at the very latest. Filing claims to secondary, tertiary policies etc will be the responsibility of the patient as we only file to primary insurances that we are in-network with. It is the patient's responsibility to confirm which policy is primary.

Insurance Billing and Payment: It is sometimes necessary for our billing department to request the patient to get involved with claim processing issues. 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. Final claim determination is the sole discretion of your insurance plan regardless of benefits states. The patient is ultimately responsible for payment in full for services rendered, not the insurance company. In the event your insurance company does not process claims(s) according to the benefits stated the balance will be 100% patient responsibility and payment is due immediately. Any claims still pending with the insurance carrier after six (6) months from the filing date is the responsibility of the patient.

Referrals/Authorizations: We do not accept any insurance plans that require referrals. It is the responsibility of the patient to know if their primary insurance policy requires prior authorizations and/or pre-certifications. If your insurance policy requires authorization an approval must be received prior to starting any treatment cycles. If proper authorization is not obtained, the patient is responsible for paying for the unauthorized service in full. As a courtesy, our office will check benefits and will submit a prior authorization request on behalf of the patient. It is common for insurance companies to misquote benefits including if a prior authorization is required.

Labs: DFW Center for Fertility & IVF will perform certain endocrinology lab services within its office lab. DFW Center for Fertility & IVF I utilizes a separate, out-of-network independent laboratory provider for andrology and embryology laboratory services. Therefore, services provided by this independent laboratory will **NOT** be covered by insurance and will be cash-only. Any specimens (i.e. blood work) that must be 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.

Please note that all office policies and fees are subject to change at any time without notice. Our practice is committed to providing high quality care to our patients at affordable prices. Thank you for choosing DFW Center for Fertility & IVF.

I authorize payment of medical benefits directly to the physician or supplier of treatment. I understand and agree that I am ultimately responsible for my account for any professional services rendered, regardless of my insurance status. I agree to pay for the services rendered even though my insurance company may determine that the services are not necessary or not covered. I agree to be responsible for any billing charges, finance charges, collection fees, and/or attorney fees assessed to my account should it become delinquent.

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

Printed Name of Patient

Signature of Patient

Date

**Consent for Electronic Communications ("EC")
via Electronic Mail and/or Electronic Text Messages**

DFW Center for Fertility & IVF can communicate with you regarding your care via electronic e-mail and/or text message. However, we want you to be aware that EC is not considered a secure form of communication - there is risk that your individual and/or identifiable health information and/or other sensitive information may be contained in EC that may be misdirected, disclosed and/or intercepted by unauthorized third parties. EC may expose you to the following risks:

- The transmission of information via EC is not always secure and can be circulated, forwarded and/or otherwise broadcast to unintended recipients;
- Backup copies of EC may exist even after the sender and/or the recipient has deleted his or her copy;
- On-line, telecommunications and/or internet services providers may have a right to inspect EC sent utilizing their services;
- EC can be used as evidence in a legal matter;
- EC may be intercepted, altered, forwarded and/or used without authorization or detection.

This is not meant to be an exhaustive list of risk(s) to you when utilizing EC to communicate with DFW Center for Fertility & IVF and there may be novel and/or unknown risks that are not yet clarified and/or provided in this consent.

Finally, please do not utilize forms of EC for urgent and/or emergent clinical problems or concerns.

Signature(s): I/we wish to communicate with DFW Center for Fertility & IVF, its providers, employees and/or authorized agents via EC, and indicate my/our acceptance of the above risk(s) by signing below. This consent has continuing force and effect unless revoked in writing.

Printed Name of Patient

Signature of Patient

Date

Prescription History Consent

I hereby authorize DFW Center for Fertility & IVF physicians and staff to view and download my external prescription history in the RxHub service in my medical record.

I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by my providers and staff here, and it may include information about prescriptions filled over the past several years.

My signature below certifies that I have read the consent form and that I understand the scope of my consent.

I hereby: _____ Authorize _____ Decline

Printed Name of Patient

Signature of Patient

Date

Receipt Acknowledgement for the Notice of Privacy Practices

I have reviewed DFW Center for Fertility & IVF's **NOTICE OF PRIVACY POLICIES** (available at www.dfwfertility.com), detailing how my information may be used and disclosed as permitted under federal law and state law. I understand the contents of the **NOTICE**, and I request the following restriction(s) concerning the use of my personal medical information:

I authorize the release of my medical information (protected health information) to the following:

1) Name _____	Relationship: _____	Phone: _____
2) Name _____	Relationship: _____	Phone: _____
3) Name _____	Relationship: _____	Phone: _____

I understand that this authorization will be effective for my lifetime unless revoked.

I understand that I may revoke this authorization at any time by notifying DFW Center for Fertility & 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 & IVF prior to their receipt of the revocation.

Printed Name of Patient

Signature of Patient

Date

Laboratory Services Addendum

Please be advised that the Embryology & Andrology laboratory, Raintree Fertility Laboratory, at DFW Center for Fertility & IVF is a separate entity and independent laboratory.

Services provided by Raintree Fertility Laboratory will be considered **out-of-network** and will be **cash pay only**. This does not include laboratory blood work. Please do not hesitate to address questions or concerns regarding this with our office staff.

By signing below, you understand that your insurance will NOT cover services provided by the independent laboratory, and you are subject to the rates contained in the Good Faith Estimate for Health Care Items and Services.

Printed Name of Patient

Signature of Patient

Date

DFW Center for Fertility & IVF - 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.

I understand that DFW Center for Fertility & IVF and its providers do not provide primary care nor preventative care services, such as a PAP smear evaluation, breast examination, mammography, colonoscopy, vaccinations, etc. I understand that these services should be obtained through my primary care provider and/or my general OB Gyn provider. I also understand that DFW Center for Fertility & IVF will not provide me with a schedule of when these tests are needed and that it is my responsibility to follow up with my primary care provider for this schedule and to complete these tests in a timely manner per published guidelines and recommendations. I attest that I will keep my preventative care services and testing up to date and share information of these test results with DFW Center for Fertility & IVF and its providers.

Understanding all of the above, I hereby provide 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 or 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.

Raintree Fertility Lab, LLC - Patient Consent to Treatment

CONSENT TO TREAT: I hereby grant permission to Raintree Fertility Laboratory, LLC (the "Lab") to perform certain andrology and embryology laboratory tests ordered by a physician in furtherance of my consent and authorization for fertility treatments by DFW Center for Fertility and IVF for medical diagnostic and treatment purposes, which may include obtaining specimens of blood by venipuncture or finger stick. I authorize the Lab to obtain these screening results and mail them to me at the above address.

I agree to pay for the tests in full at the time of service. I understand that the Lab is cash-only and will not submit the tests to any insurance company for reimbursement.

I further understand that the test results will not be forwarded to my medical professional for diagnosis of my medical condition.

I certify that I have read the above acknowledgements and have had the opportunity to ask questions about its contents. By signing below, I consent to undergo the laboratory testing under the conditions set forth herein. I understand that no warranty or guarantee will be made to me as to result of any testing results, treatment or cure of my condition. I will have the opportunity to ask questions about my condition and treatment, risks of non-treatment and the diagnostic laboratory services to be provided by the Lab, I believe I have sufficient information to give this informed consent. I hereby consent to treatment.

Printed Name of Patient

Signature of Patient

Date

Genetic Carrier Screening

Why should I undergo genetic carrier screening?

The doctors and staff at DFW Center for Fertility & IVF do our best to ensure that you receive optimal care and attention to improve your chances of having a healthy pregnancy and child. An important part of family planning is being informed about your testing options. Genetic carrier screening is one test that may help you better understand the chance to have a child with a genetic disease.

Nobody in my family has any history of a genetic disease, so why should I be screened?

Carriers of certain genetic diseases are usually healthy individuals; but when both parents are carriers of the same genetic disease, they can have a child with that disease. Most people do not know they are carriers until they have a child born with the disease. If both you and your partner are carriers for the same disease, your child typically has a 1 in 4 (25%) chance of having that disease.

What diseases would I be tested for if I elect to undergo genetic carrier screening?

DFW Center for Fertility & IVF recommends all patients undergo genetic carrier screening through a single blood or saliva test that screens for many genetic diseases – many of which you probably have never heard of before – each with its own unique features. Some disorders impact intellectual ability, while others impact physical ability. Some decrease lifespan, while others impact daily life. Some have treatment options, like lifelong medications or restrictive diets. Here are a few of the more common diseases:

- Cystic fibrosis: chronic disease of the lung & digestive systems that shortens the lifespan; may also impact male fertility and cause an increased risk for infectious disease.
- Spinal Muscular Atrophy: progressive weakness of the muscles affecting breathing, swallowing, head/neck control and walking; varying degrees of severity exist, but the most severe and common form shortens lifespan to about 3-5 years.
- Fragile X syndrome: moderate to severe intellectual disability; behavioral problems in males; characteristic facial features.

Like any carrier screening test, some carriers will not be detected – so this test can reduce, but not eliminate, the chance for a genetic disease. As the United States population is becoming more ethnically blended, the ability to make appropriate recommendations based on ancestry alone is reduced. Thus, we recommend an inclusive approach to genetic testing and elected to offer patients expanded carrier screening.

Given the large number of diseases included in expanded carrier screening, we estimate that nearly half of our patients will be found to be a carrier for at least one of the conditions for which we are testing. So, if you are currently pregnant, you may want to consider having both you and your partner be tested at the same time. Since many disorders require that both members of the couple be carriers for there to be an increased risk to have an affected child, testing at the same time will provide results more quickly.

Why should I be tested if there is nothing I can do to change my genes?

If you are found to have a high reproductive risk, you have options. You may decide to have preimplantation genetic diagnosis (a pre-pregnancy process that significantly reduces the risk that a child will inherit the genetic disease) or undergo testing during pregnancy to make informed reproductive decisions. Some individuals consider adoption or opt not to have children. Even if you would not choose any of these options, you can use the information to prepare for the birth of a child with a genetic disorder. You will have the opportunity to speak with your physician or a genetic counselor about the medical options available to you.

Isn't genetic testing expensive?

Genetic carrier screening is covered by most insurance plans, however, copays, co-insurance, and/or deductibles may vary by health plan. To determine what your out-of-pocket expenses may be, please contact our office for more information.

I was offered carrier screening and will consider this option. I will let the office know if I would like to pursue testing.

Printed Name of Patient

Signature of Patient
4863-6951-7118, v. 1

Date