**Privacy Notice: 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.** The physician and staff of DFW Fertility Associates are committed to maintaining the confidentiality of your personal, non-public information (PHI). During the course of your evaluation and treatment, it is necessary to collect personal, non-public information as well as your personal medical history. This may include your social security number, employer name, insurance benefits, address and telephone numbers. This information will be held in strict confidence and may be released only upon your written request. Non-public, personal information about our patients will not be disclosed unless required by law. We do not sell any information about our patients to mailing list companies, mass marketing organizations, pharmaceutical companies or any other company as expected in a doctor-patient relationship.

Your personal medical history is obtained during the course of your evaluation and treatment. This medical information may include personal information of substance abuse, psychiatric treatments, HIV, surgery, and/or genetic test results. Insurance companies sometimes request your personal medical information (without notifying you) from a physician's office before a claim is paid. Please note that the Release of Information section below allows DFW Fertility Associates to release your personal medical information to an insurance company in order to secure payment of a claim. We use this information only to file health insurance claims on your behalf, conduct company business, and fulfill legal requirements.

Your personal medical information may also be shared with healthcare providers outside of this office who are participating in your care. Examples of these healthcare providers include your referring physician to whom a copy of your initial consultation and/or progress notes may be provided, Presbyterian Hospital of Dallas if undergoing a treatment within that hospital, a pharmacy, or perhaps another physician or genetics counselor if you are referred by DFW Fertility Associates. In addition, the office may release your PHI to other individuals and businesses in order to perform its day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for credentialing and peer review, patient satisfaction surveys, utilization review/utilization management, billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, free standing diagnostic facilities and legal counsel. DFW Fertility Associates requires all its business associates to agree to appropriately protect the confidentiality of your personal, non-public information.

We treat your information as strictly confidential, and we maintain physical, electronic and procedural safeguards to protect your personal information. Our employees receive instructions about the importance of maintaining the confidentiality of our patients' information, and those employees who have access to our patients' non-public, personal information are those who need it for business purposes. We respect our current and former patients' privacy and seriously regard the responsibility to treat your information as strictly confidential.

Finally, the physician and staff of DFW Fertility Associates expect our patients to respect the privacy of other patients whom you may know or meet while undergoing treatment at this clinic.

**Assignment of Benefits and Release of Information:** I hereby assign all medical insurance benefits to which I am entitled to DFW Fertility Associates. 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.

I hereby authorize DFW Fertility Associates to release any and all medical records including medical, surgical, psychiatric, substance abuse, HIV and genetic information which may be found within the records needed to secure payment or determine benefits from insurance payers and other third party administrators. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and understand the Privacy Notice and Assignment of Benefits and Release of Information policies contained herein.

Patient Signature _____ Date _____

Print Name _____

**General Consent for Treatment:** I authorize and direct DFW Fertility Associates to perform upon me diagnostic evaluation and medical treatment that the physicians, in their judgment, determine advisable for my well being. As a patient's right, I expect the physicians and/or staff to explain the nature and purpose of the recommended evaluation and treatment, as well as possible alternative methods of treatment and the risks and complications involved. If any surgical procedure is recommended, a separate and distinct consent will be sought. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any evaluation and medical treatment.

**Financial Policy:** All services rendered including office visits, procedures, laboratory fees and co-payments are payable at the time of the service. We accept checks, Visa, MasterCard, Discover and American Express. If you have precertified your insurance coverage with our office, we will gladly file the covered services with your insurance company. If your insurance changes during your treatment, it is your responsibility to notify us in a timely manner. PLEASE NOTE, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN IF ONE IS REQUIRED.

If your insurance can not be verified, or your insurance company does not cover infertility, payment in full is due at the time service is rendered. Please note, it is our policy to code your diagnosis as infertility if you are undergoing fertility treatment. We will not intentionally miscode fertility treatment with a different diagnosis if your insurance carrier excludes infertility treatment.

Frequently, an insurance carrier may not pay the full amount of the physician's services rendered. While this office will file claims and attempt to negotiate disputed claims with your insurance carrier, the patient is responsible for payment of services rendered. DFW Fertility Associates acknowledges that some physician services will be paid by an insurance carrier at a discounted fee, provided that a valid contract exists with your insurance carrier and this office.

The patient will be responsible for any payments required by their insurance carrier.

**STD Screening:** Chlamydia and gonorrhea (GC) infections are the two most common bacterial sexually transmitted diseases in the U.S. If left untreated, they can result in pelvic inflammatory disease causing infertility. If present in pregnancy, such an infection may contribute to early pregnancy loss. Each year an estimated 1 million American women develop PID and an estimated 100,000 become infertile as a result of PID. This is because most Chlamydia infections are "silent" or cause no symptoms, so they may not be diagnosed and treated until complications have developed. Chlamydia and GC testing is commonly done and <u>will be performed on your initial pelvic examination in this office</u>. Chlamydia and GC tests may or may not be covered by your insurance company. However, this office has determined that the benefits of this screening far outweigh the associated costs and have included it as a part of every patient's infertility evaluation here.

**HIV Screening:** I authorize DFW Fertility Associates to test my blood for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, prior, during or after fertility treatment or surgery.

I have read and understand the General Consent, Financial Policy, STD Screening, and HIV screening contained herein.

Patient Signature _____ Date _____

Print Name _____