Dallas IVF
DALLASIVF.COM

BRIAN D. BARNETT, M.D. ● LOWELL T. KU, M.D. ● DARA L. HAVEMANN, M.D.
SARA J. MUCOWSKI, M.D. ● RINKU V. MEHTA, M.D.

PATIENT/RESPONSIBLE PARTY AUTHORIZATION

Patient Name: _____ **DOB:** _____

Employer: _____

Race: ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Indian ☐Other_____

Emergency Contact: Name: _____ Relationship to patient: _____

Phone Number: (____)_____

Preferred Pharmacy: _____

Phone Number: (_____)_____

To all patients of Dr. Brian D. Barnett, Dr. Lowell T. Ku, Dr. Dara L. Havemann, Dr. Sara J. Mucowski, or Dr. Rinku Mehta:

I authorize release of medical information to process claims. I request that payment of medical benefits be made to Dr. Brian D. Barnett, Dr. Lowell T. Ku, Dr. Dara L. Havemann, Dr. Sara J. Mucowski, or Dr. Rinku Mehta and understand that this is automatic in case of hospitalization. This assignment of benefits will remain in effect until revoked by me in writing.

_____ _____

Patient/Responsible Party's Signature Date

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may retain a revised copy by request from the receptionist. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

_____ _____

Patient's Signature Date

OFFICE POLICIES

1. We understand that delays can happen, however we ask all our patients to be on time so that we can stay on schedule and minimize patient inconvenience. Please call the office if you are running behind.
    - **$15 Rescheduling Fee**- If you are 15 minutes past your scheduled time, we may need to reschedule your appointment and there will be a $15 fee. Sonogram appointments are scheduled every 15 minutes, if you are late, it will delay your original appointment time.
    - **$25 Cancellation Fee**- If you No Show or Cancel an appointment without giving a 24-hour notice, there will be a $25 fee.

    ****Please note, cancellation and rescheduling fees are not billable to insurance****
2. For the safety of our patients and their children, no children will be permitted in the sonogram rooms unless restrained in a stroller or attended to by another adult. Children may **not** be left unattended in the waiting room. Our office staff cannot be responsible for supervising children.
3. Phone calls are returned within 24 hours. If you are experiencing symptoms of concern please alert any member of our team, a nurse will call back as soon as possible during the business day.
4. Dallas IVF offers a discount of 15% for military, service personnel, and teachers. The discount only applies to the infertility procedure itself and not diagnostic exams or in treatment ultrasounds and labs. You are eligible for the discount if you or your partner is a member of the military, a veteran, a police officer, a firefighter, an EMT, or a teacher. We are unable to apply discounts to claims submitted through insurance, so the discount is only applied if you are self-pay for your procedure with Dallas IVF. This discount excludes the following services; embryo biopsy, PGT testing, cryopreservation, and anesthesia fees.
5. **It is the patient's responsibility to know their insurance coverage.** Your insurance policy is a contract between you and the issuer of your insurance policy. Therefore, you as the policy holder not Dallas IVF is responsible for knowing your insurance benefits, i.e. what is covered, what is not covered, if there are prerequisites for coverage, if a pre-authorization is required, etc. To avoid any misunderstanding, you are encouraged to discuss fees and benefits with your insurance company prior to treatment.
6. If your insurance plan requires you to have a referral from your PCP, it is your responsibility to ensure that the authorization process is completed prior to your initial visit. If no referral is on file at time of service, you will be charged the self-pay rates. You will be financially responsible for any charges denied by your insurance company due to non-presentation of a referral and/or authorization from your PCP.
7. If you request for our office to file a claim to a 3rd party payer (insurance carrier) on your behalf, please be advised that it may take 30-60 days to receive approval/denial from your insurance company after claims have been processed. You will be responsible for paying all costs that are not paid by your insurance carrier. If you do not have infertility treatment coverage, then you will always have the right to pay our self-pay rates and not file with your insurance. If we receive a denial from your insurance company, we will inform you upon your next visit and convert to self-pay at that time.
8. If you do not present our office with an insurance card at the time of service, you will be charged as a private pay patient. A receipt can be provided so that you can file the claim for reimbursement from your insurance.
9. Dallas IVF uses LabCorp as the preferred provider for all pathology services, if LabCorp is not listed by your insurance as a preferred/covered provider, reduced self-pay options will be provided. Patients may also go to an outside lab of their choice with a requisition from Dallas IVF.
10. If you require additional copies of your medical records, there will be a processing fee of $25.00.

11. Regarding all scheduled surgeries: If you need to postpone surgery for any reason other than an unforeseen emergency (which will require documentation from a physician or employer, etc..) there will be0 a $200 fee due at the time you reschedule.
12. A collection fee of 25% will be added to all accounts that are turned over to a collection agency.
13. Dr. Brian D. Barnett, Dr. Lowell T. Ku, Dr. Dara L. Havemann, Dr. Sara J. Mucowski, or Dr. Rinku Mehta share after hour coverage as well as office coverage for weekends and holidays. It is necessary for medical care to release or disclose certain medical information to these physicians.
14. There is an additional $30.00 fee for appointments that are required over the weekend or on a holiday. If you have insurance coverage for these procedures, we will bill the insurance for this charge. However, if they deny payment, you will be responsible for this $30.00 charge.

_____ _____

Patient or Guardian's Signature Date

Consent to Treatment: I certify that I am the patient and/or the legal guardian of the patient and I consent to treatment necessary for the care of the patient on this form. _____
Initial

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by my insurance including, without, limitation, my deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits are assigned. Any account with a balance greater than $100 will be restricted from further scheduling until the balance is paid in full. Frisco Fertility Center files claims for any insurance plans which we participate with. We accept payments made with cash, check, or Visa ®, Mastercard ®, Discover ®, American Express ®. If you plan to pay by check and it is dishonored, a processing fee of $35.00 will be assessed and we will no longer accept checks as a form of payment.

Pre-Payment: Dallas IVF requires payment for non-emergency surgeries and procedures 2 business days prior to the scheduled service. Failure to remit payment 2 business days prior will result in the cancellation of your scheduled surgery or procedure. Any services provided leading up to the cancellation will not be refunded.

Payment Plans: It is the policy of Dallas IVF that payment in full is due at the time of service and that payments to cover amounts that were not paid by insurance are due immediately upon receipt of your statement. Therefore, we are not able to set up payment plans.

Assignment of Benefits: I assign to Frisco Fertility Center all payments for my medical services rendered to myself or my dependents filed to my insurance on my behalf.

_____ _____

Patient or Guardian's Signature Date

Authorization for Release of Medical Information: I hereby authorize Dallas IVF to release any medical or incidental information that may be necessary for medical care or to process medical claims for which payment is assigned to the

provider. Please list any physician you would like Dr. Brian D. Barnett, Dr. Lowell T. Ku, Dr. Dara L. Havemann, Dr. Sara J. Mucowski, or Dr. Rinku Mehta to share information with:

_____

I acknowledge that telephone calls from our office may be returned to my cellular telephone _____
Initial

I authorize that messages may be left for the patient regarding patient care. Please initial: At work: _____
On a home answering machine: _____ With a spouse or family member: _____

I authorize that emails may be sent to me regarding patient care: _____
Initial

I give permission for my protected health information to be disclosed for purposes of communication results, findings, and care decisions to my spouse, partner, and/or family members and others: ☐ Yes ☐ No
If yes, please list those persons below:
Name: _____
Name: _____

POLICY FOR RECEIVING MEDICAL RECORDS FROM ANOTHER PHYSICIAN: I understand that any medical records that I bring to my appointment today from another physician cannot be copied and/or released after today. Our office will be happy to make you a copy of these records today, but once they become part of your chart, we do NOT release other physicians' records to the patient or any other physician.

MEDICATION INSTRUCTION NOTICE: A medication instruction with a nurse may be requested by your physician. This appointment type allows the nurse to thoroughly instruct you on the ways to administer the recommended medication. The fee for a medication teaching is $40 and this appointment type cannot be filed with your insurance company.

_____
Initial

FEES FOR BLOOD/LABORATORY STUDIES: The preferred laboratory for blood studies at Dallas IVF is **LabCorp**. If your insurance company is not contracted with LabCorp, but with another laboratory, you will be financially responsible for the cost of laboratory/blood studies obtained in our office. Reduced self-pay options will also be provided. Patients may also take a laboratory requisition slip to their preferred pathology services' draw center. If a patient chooses this option, Dallas IVF is not responsible for timeliness of the results and the subsequent effect on timeliness of treatment. Blood studies done on a weekend or holiday will be sent to Labcorp only.

I have read and understand the above information provided to me regarding laboratory studies requested either by Dr. Brian D. Barnett, Dr. Lowell T. Ku, Dr. Dara L. Havemann, Dr. Sara J. Mucowski, or Dr. Rinku Mehta. I understand that I will be financially responsible for these charges if my insurance company is not contracted with LabCorp. _____
Initial

OUT OF NETWORK NOTICE: Dallas IVF Surgery Center and Dallas IVF Lab are out of network facilities. Your physician has referred you to or arranged for you to receive services at a non-participating, out of network facility. You have the right to seek care at a participating facility in order to obtain full benefits under your health insurance coverage.

Insurance claims that are filed on behalf of Dallas IVF Surgery Center and/or Dallas IVF Lab will be processed as out of network claims in accordance to your out of network benefits. Any payment that is made towards your deductible

and/or coinsurance will be applied towards your out of network deductible and/or your out of network coinsurance. Dallas IVF will balance bill for any remaining payment not remitted by your insurance company. Please, refer to your insurance contract or contact your insurance carrier for information regarding your out of network benefits.

Your signature below indicates that you have read and fully understand the statements that are listed above and that you are voluntarily choosing to have your procedure(s) performed at an out of network facility.

_____ _____

Patient or Guardian's Signature Date

USE OF RESIDENT PHYSICIANS: Dallas IVF participates with Baylor Scott & White clinical education program in the Department of Obstetrics and Gynecology to give resident physicians educational experience in clinical practice specifically in the field of Reproductive Endocrinology and Infertility. Your physician has agreed to permit Ob/Gyn resident physicians to participate in his/her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

By signing below, you agree to permit the Ob/Gyn resident physicians working in your physician's office to observe and participate in your medical care during your visits at Dallas IVF. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointments.

_____ _____

Patient or Guardian's Signature Date

SOCIAL MEDIA: I grant Dallas IVF permission to share my infertility journey on DallasIVF.com and social media sites to include text, pictures, or videos of myself and/or child/children, these may include thank you cards, updates, and baby pictures. I understand that I have the right to request, in writing, removal of the information, and Dallas IVF will have 30 days from receipt of this request to comply with my wishes. I understand that this authorization will remain in effect until I request removal of information. I understand that this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my signing this authorization form.

_____ _____

Patient or Guardian's Signature Date

I understand that I may revoke consent for any or all of the above signed items at any time in writing. I certify that all information provided is correct.

_____ _____

Patient or Guardian's Signature Date

HIPAA Omnibus Notice of Privacy Practices

Effective Date*: *September 23, 2013

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.

If you have any questions about this notice, please contact our **Privacy Officer**

This Notice of Privacy Practices describes how we and our Business Associates may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present and future physical condition and related health care services. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI):

Your PHI may be used and disclosed by your physician, our office 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 pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

For Treatment. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and conducting or arranging of other business activities. For example, we will use a sign-in sheet at check-in where you will be asked to sign your name. We will also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your PHI information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

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 required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

The following are statements of your rights with respect to your PHI:

You have the right to inspect or copy your PHI (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or

copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your PHI – This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communications from us by alternative means or at an alternative location.

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

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations, required by law, that occurred prior to April 14, 2003, or six year prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured PHI has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We will reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our **Privacy Officer** of your complaint. Any complaint you file will be used strictly to improve our operating procedures, and in doing so, you will not be retaliated against for filing a complaint.

I have reviewed the above Notice of Privacy Practice, which explains how my medical information will be used and disclosed. By signing below, I acknowledge that I have read and understand the above and understand my rights to privacy of Protected Health Information.

Patient's Signature: _____

_____ _____

Patient's Name (Printed) Date

PATIENT CONSENT FOR USE OF EMAIL COMMUNICATIONS

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at (214) 297-0020. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24-48 business hours. Please, be advised that the service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number, if known, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

Dallas IVF is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that Dallas IVF will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical and financial related correspondence to you via email, and that we may respond to your emails to us via email.

Patient Email Address: _____

Patient Signature: _____

PATIENT BILL OF RIGHTS

Policies of a physician and facility should facilitate the protection of and not contradict these rights.

The Patient has the right to:

- Obtain, from the physician, complete and current information regarding his/her diagnosis, treatment, and prognosis.
- Considerate and respectful care.
- Receive, from the physician, information necessary to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her actions.
- Every consideration of privacy regarding his/her own medical care.
- Expect all communications and records pertaining to care be treated as confidential.
- Expect that within his/her capacity a physician must make reasonable response to the request of a patient; the right to be treated.
- Obtain information regarding the relationship of the physician to other health care and educational institutions in so far as his/her care is concerned.
- Be advised if the physician proposes to do human experimentation affecting his/her care.
- Expect reasonable continuity of care.
- Examine and receive an explanation of his/her bill, regardless of the source of payment.
- Know what physician rules and regulations apply to his/her conduct as a patient.