Dallas IVF
DALLASIVF.COM

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# PATIENT REGISTRATION AND ACKNOWLEDGEMENTS

**Patient Name:** _____ **DOB:** _____

**SS#:**_____ **Employer:** _____

Race: ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Indian ☐Native American ☐Other

**Emergency Contact:** Name: _____ Relationship to patient: _____

Phone Number: (____)_____

**Preferred Pharmacy:** _____

**Phone Number: (_____)_____**

**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: _____

**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

**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

# 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) 225-2057. 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: _____**