THE HEARD CLINIC

FERTILITY / GYNECOLOGY / ENDOCRINOLOGY

Advanced Reproductive Medicine

Patient Consent Form

Please read and sign

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments to include office visits, exams, ultrasounds, intrauterine insemination, in-vitro fertilization, frozen embryo transfer, colposcopy, cyst aspirations, biopsies, Intrauterine device removal or insertion, pap smears, pelvic and breast exams, labs, including any diagnostic tests.
- Administration of any needed anesthetics/injections
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures and tests
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that The Heard Clinic may include consent at satellite offices under common ownership.

I, the undersigned, authorize The Heard Clinic to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given The Heard Clinic Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient (or Responsible Party)
Initial:

_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party or Legal Guardian of a Minor) Signature Date

THE HEARD CLINIC

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

To: New Patients on Date of First Visit with Dr. Michael J. Heard

During the course of your physician/patient relationship with Dr. Heard, Dr. Heard may refer you to Westside Surgical Hospital. The address of the Facility is 4200 Twelve Oaks Dr., Houston, TX 77027.

In connection with any referral to the Facility, you are hereby advised that Dr. Heard has an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of Dr. Heard's first contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or the Facility if you choose to use a different facility.

Should Dr. Heard at any time refer you to the Facility and you prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

Patient name (please print) _____

Patient signature _____

Date _____

THE HEARD CLINIC

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Advanced Reproductive Medicine

PATIENT REGISTRATION

THANK YOU FOR CHOOSING OUR CLINIC. IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION. PLEASE PRINT. ALL INFORMATION WILL BE CONFIDENTIAL.

Date: _____

Patient Name: _____ **Email Address:** _____

Cell#: _____ **Wk#:** _____

Marital Status: [ ] Single [ ] Married [ ] Other **Occupation** _____

SS#: _____ **Sex: [ ] Male [ ] Female** **Birthdate:** _____

Address: _____ **City** _____ **State** _____ **ZIP** _____

How did you find this clinic? [ ] Yellow Pages [ ] Clinic Sign [ ] Drive By [ ] Friend/Relative [ ] Other.

Emergency Contact _____ **Home #:** _____ **Cell #:** _____

Closest Relative: _____ **Phone #:** _____

RESPONSIBLE PARTY

Person responsible for any account balance:

Relationship to patient: [ ] Self [ ] Spouse [ ] Child [ ] Other _____

Address: _____ **City** _____ **State** _____ **ZIP** _____

Home Phone #: _____

Birthdate _____ **SS#:** _____ **License #:** _____

INSURANCE INFORMATION

Name of policy holder _____ **Relationship to patient:** _____

Birthdate _____ **SS#:** _____ **Date Employed:** _____

Name of Employer _____ **Occupation** _____

How much is your deductible? _____ **Amount of deductible Met?** _____

Max Annual Benefit? _____ **Type of Insurance: [ ] PPO [ ] HMO [ ] Other**

ASSIGNMENT OF INSURANCE BENEFITS / CONSENT FOR TREATMENT

I give my consent to the administration and performance of all diagnostic procedures and treatment, which may be considered necessary. I hereby authorize The Heard Clinic to furnish Information and payment of medical benefits to services rendered. I certify that the information given by me in applying for payment Is correct 1 request that payment of authorized benefits be made on my behalf. A copy of this is deemed as an original.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I have read a copy of the Notice of Privacy Practices.

Patient Name (please print) _____

Parent/Guardian (please print) _____ Date: _____

Parent/Guardian Signature _____

THE HEARD CLINIC

FERTILITY / GYNECOLOGY / ENDOCRINOLOGY

Advanced Reproductive Medicine

AUTHORIZATION TO RELEASE/OBTAIN HEALTH CARE INFORMATION

Patient Name: _____ **DOB:** _____

SSN: _____ **Previous Name:** _____

□ Authorization to release my medical records to me
□ Authorization to send my medical records to Dr. Heard
1315 St. Joseph Pkwy, Houston, TX 77002, Suite 1305
Phone: 713) 878-0878 Fax: 713) 654-8795
□ Authorization for Dr. Heard to send my medical records to:

Doctor: _____ **Phone Number:** _____

Address: _____

□ Health care information relating to the following treatment, condition or dates of treatment
_____
□ All health care information

□ Other: _____

Reason you are requesting Medical Records to be sent: _____

_____ Transferring Care to another Doctor

_____ Second Opinion _____ Pregnant and Need an OB

_____ Moving _____ Price/Not on my insurance plan _____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that I may revoke this consent for release for medical records at any time except to the extent that action has been taken in reference to it. If you chose to revoke consent, it must be done in writing. **I also understand that a fee for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Medical Examiners.**

Signature: _____ Date: _____
(Signature of patient or patient's authorized representative)
Print Name: _____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)
Authorization to FAX: □ Yes □ No

THE HEARD CLINIC

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Advanced Reproductive Medicine

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable Insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health cafe provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA branch of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings: (S) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or Insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient name (please print)_____

Patient Signature_____

Date_____

THE HEARD CLINIC
FERTILITY / GYNECOLOGY / ENDOCRINOLOGY
Advanced Reproductive Medicine

MALE PATIENT INFORMATION

Personal Information

Name: _____ **DOB:** _____
HT:_____ **WT:** _____

Address:

_____

Home: _____ **Cell:** _____

Ethnic Origin:_____ **Occupation:**_____

SS#: _____ **Married: Yes** _____ **No** _____ **Years:** _____

Spouse's Name: _____

_____

Personal Habits & General Information

Check all that apply

☐**Alcohol Use: How many glasses per week do you usually drink? Wine** _____ **Beer** _____ **Cocktails** _____

☐**Do you smoke? Daily** _____ **Occasionally** _____ **Rarely**_____ **Never** _____
If yes, how many packs per day? _____
If you did smoke, but quit, when did you last smoke?____
How many packs/day? _____ **for how many years?** _____

☐**Illicit or recreational drugs (Marijuana, Cocaine, Etc.)**

_____

Have you had testicular or pelvic surgery? ☐Yes ☐No
If yes, specify date and type:

_____

Have you ever been treated for cancer? ☐Yes ☐No
If yes, specify date and type.

_____

HISTORY OF FERTILITY THERAPY (Check all that apply)

Which of the following tests have you had performed? Check all that apply and the results if known:

Test	When	Results
☐Semen analysis	_____	_____
☐Chlamydia test	_____	_____
☐Hormonal Assays FSH, LSH	_____	_____
Prolactin, Testosterone	_____	_____
☐Chromosome Test	_____	_____
☐Sperm Antibody Test	_____	_____
☐Testicular biopsy	_____	_____
☐Thyroid Tests	_____	_____
☐X-ray or ultrasound of testes	_____	_____

☐Other
Specify
_____

Have you been treated for infertility before? ☐Yes ☐No
If yes, who was your physician? _____
What cause of infertility was diagnosed? _____
Treatment _____

Do you have knowledge whether you have ever been exposed to any of the following drugs or toxins?
In Utero: ☐Diethylstilbestrol ☐Antiandrogens
Occupational Exposure: ☐Carbon Disulfide ☐Lead
☐Estrogens ☐Cholordectone ☐Ethylene Glycol
Prescription Drugs: ☐Chemptherapuetic Agents ☐Sulfasalzine ☐Androgens

LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY

☐Self, your parents, siblings, children, aunts, uncles, grandparents, cousins
_____
_____

MEDICATIONS

List ALL current medications or treatments (include vitamins, aspirin, antacids, laxatives, etc):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Usual Weight? _____ # lbs recently lost or gained? _____
Have you been tested for HIV? _____Yes _____No;
If yes, Results _____

Allergies (medicines, food, pollens)? _____Yes _____No
If yes, list kind:

CHECK THE APPROPRIATE SPACE FOR CONDITIONS OCCURING NOW OR IN THE PAST

☐HIV/AIDS
☐ALLERGIES: LIST _____
_____
☐ANEMIA
☐Appendicitis
☐Arthritis
☐Bleeding or bruising
☐Blood Clots
☐Blood Transfusion
☐Cancer, specify: _____
_____
☐Chlamydia
☐Chest pain, Pressure
☐Colitis
☐Convulsions, Seizures
☐Diabetes
☐Diarrhea
☐Dizziness, Fainting
☐Excessive sweating
☐Epilepsy
☐Gallbladder problems
☐Gonorrhea
☐Goiter, Thyroid
☐Heart trouble
☐Hernia
☐Hepatitis, Jaundice
☐Herpes
☐High Blood Pressure
☐Kidney Infection
☐Liver problems
☐Lymph node
☐Measles: German
☐Measles: Regular
☐Murmurs
☐Neurological Problems
☐Pneumonia
☐Prostate Enlargement
☐Prostatitis; Bacterial
☐Poor Appetite
☐Psychiatric disorders
☐Pains in Joints
☐Rheumatic fever
☐Seizures
☐Sexual Problems
☐Shortness of breath
☐Sore throats
☐Swollen Joints
☐Syphilis
☐Testes Infection
☐Testes injury
☐Tuberculosis
☐Ulcers
☐Urinating
☐Wheezing, asthma
☐Other:
_____

THE HEARD CLINIC
FERTILITY / GYNECOLOGY / ENDOCRINOLOGY
Advanced Reproductive Medicine

Michael J. Heard, M. D.
Reproductive Endocrinology and Infertility
Phone: 713-878-0878 Fax: 1-866-788-2859

Patient Information Form

Welcome to **The Heard Clinic**. Providing you excellence in care and service is our most important goal. In order to fulfill this commitment to you, we request that you please consider carefully the following information.

Check In:

- Please inform the front desk if you have been waiting longer than 20 minutes for your appointment.
- Patients that arrive more than 15 minutes late for their appointment may be seen, but their appointment time may be shortened.
- Patients that arrive more than 30 minutes late for their appointment are considered "late" and may be asked to reschedule based on schedule availability.
- Patients that fail to reschedule an appointment or "No Show" for an appointment may be subject to fees related to that appointment type. Please contact our clinic immediately if you will not be able to make a scheduled appointment.

Check Out:

- Please make sure to schedule or confirm your next appointment with Dr. Heard's staff prior to leaving the clinic.
- Please proceed to the lab if blood work has been ordered prior to checking out. Take paperwork to check-out at the end of your appointment.

Lab Work:

- Same day labs are usually reported the NEXT BUSINESS DAY. Labs may be available the same day but Dr. Heard's office has no control over delay in labs performed through the laboratory. Dr. Heard, or his staff, will contact you if it is necessary for you to be informed of important lab results. Otherwise, you will be contacted within 7-10 business days of any lab results.
- In addition, some lab results require a follow-up in the office for detailed discussion with patients and will <u>not</u> be handled over the phone.

Weekend / After Hours:

- Patients seen at this time will see either Dr. Heard or his nurse.

- If you need to reach the office after-hours or on weekends, please call the answering service and they will contact Dr. Heard or his nurse. **Answering Service 713-878-0878**
- Please call for ALL-cycle starts on day one of full flow or any important issues concerning medications or treatment problems regardless of weekend or holiday.

Medical Records:

- Texas Law allows 15 business days from the receipt of medical release form (s) before medical records must be sent to the patient or new provider. The Heard Clinic follows this policy.

Refills:

- NO REFILLS will be given on diet pills, pain medications, or oral contraceptives/hormones without the patient having current updated office visits in the medical record.
- Please call your Pharmacy for any refills of medication you may need. The pharmacy will contact us if they need authorization. Please allow up to 72 hours for refills to be processed.

Insurance/Billing:

- For questions related to medical billing, please contact Supreme Medical Company (SMC) at 832-328-6638.

Phone Calls:

- Please allow 48 hours for messages to be returned. If your call is urgent, do not leave a message, speak to a staff member or call 911 for an emergency.

Letters/Disability Paperwork:

- Please allow 10 business days for the letter to be written. The fee for Letters of Medical Necessity, for insurance purposes, is $150.00 and must be paid prior to receiving the letter. This fee is not charged to your insurance.
- For Disability/FMLA paperwork, the fee is $25.00. Please allow 10 days for this to be completed.
- Any additional paperwork may incur a fee.

Complaints/Accommodations:

- If you are dissatisfied with your visit or the office in any way, or you want to give accommodations where deserved, please do not hesitate to contact our office and speak with Dr. Heard or his staff Your comments/concerns will be addressed promptly and referred to the appropriate management staff for review.

By signing this Patient Information Form you agree with the processes and requests of The Heard Clinic.

Signature: _____ **Date:** _____

I authorize The Heard Clinic to leave me a voicemail to convey messages if I am unreachable by phone Yes ☐ No ☐

THE HEARD CLINIC

FERTILITY / GYNECOLOGY / ENDOCRINOLOGY

Advanced Reproductive Medicine

Diagnostic Lab Studies Performed at The Heard Clinic

Date:_____

Dear Patient,

All laboratory testing performed is coded appropriately at the time of the office visit. Tests may be performed according to medical needs of the patient. All are deemed medically necessary. All laboratory testing will be submitted to insurance when applicable. Please be aware that not all tests may be covered by insurance due to an individual patient policy. It is the patients' responsibility to be accountable for any labs that may not be covered. Any questions regarding your insurance coverage concerning labs should be directed to your insurance company and not to The Heard Clinic.

Regards,

The Heard Clinic

I have read the above information and understand the current policies with laboratory testing at The Heard Clinic through St. Joseph Hospital.

_____

Signature of Patient

_____

Signature of Dr. Michael Heard

_____

Date

THE HEARD CLINIC

FERTILITY / GYNECOLOGY / ENDOCRINOLOGY

Advanced Reproductive Medicine

PATIENT FINANCIAL POLICY

The Physicians and staff at The Heard Clinic thank you for choosing us for your health care needs. Our commitment to you includes providing quality medical care when and where you need it most, and providing excellent customer service through effective communication and understanding.
Making sure you are aware of your financial responsibilities is part of our commitment to you. Please carefully review our financial policy below. Thank you for your cooperation.

Health Plans

The Heard Clinic participates with many health plans and managed care programs. If you are a member of one of these plans, we will file claims for services rendered. Please be aware:

- It is your responsibility to determine whether The Heard Clinic is listed as an in-network or out-of-network provider under your health plan.
- For assistance, contact your health plan's Member Services department.

Registration and Check In

Before or at your initial visit, and periodically thereafter, you will be asked to provide registration information to help keep personal and insurance details up to date. Please be aware:

- You will be asked to present your insurance card(s) and driver's license when you check in for each appointment. If you do not bring your insurance card with you, we will not be able to file the insurance claim for you, making you responsible for the cost of all services.
- Scanned copies of your insurance card(s) and license are kept as part of your record.
- It is your responsibility to notify our office of any patient information changes such as address, name, telephone number, or insurance information.

Payments

Payment and outstanding balances are due at time of service unless other payment arrangements have been made in advance. Payment will include known co-payments, deductibles, and coinsurance due for each visit. It is our policy to collect known payments at the time of service. If you do not make payment at time of service, a $30 billing fee will be added to your account. Please be aware:

- All fertility treatments must be paid for in FULL prior to start of treatment. NO treatments can be completed without satisfying full payment.
- While we may *estimate* your financial responsibility, it is your insurance company that ultimately determines your benefits.
- We accept cash, checks or credit cards.
- No post-dated checks will be accepted.

Responsibility for Services

While it can be The Heard Clinic's responsibility to arrange for pre-authorization of surgical services when required by your health plan, this can only be accomplished accurately when we have the correct information for your health plan(s). Please be aware:

- Keeping us updated on health plan changes is your responsibility.
- Obtaining a referral for specialist services is your responsibility.
- Certain procedures or services may not be covered, or may be considered "not medically necessary", "experimental" or "cosmetic" by your health plan. You are responsible for payment of these services.

- Some health plans limit preventive ("well") services. If your care exceeds a plan limitation, you will be responsible for payment.
- Additional charges may be incurred if, during the course of a physical exam, the provider addresses another health concern.
- Surgical patients will be asked to pre-pay co-pays, deductibles, and coinsurance.
- It is your responsibility to know or confirm if any service, procedure, medication, or supply is a covered benefit under your current health plan. You will be responsible for all charges which are not a covered benefit.
- Patients seen in ambulatory surgical centers and hospital facilities will receive separate bills from the facility and other physicians who provide care. Examples include pre-admission tests, facility charges, anesthesiology services, and pathology services.

No Show/Cancellation Policy

- A $50 charge will be assessed if a previously cancelled office appointment is again rescheduled. This charge will be paid in advance before any additional appointments can be made.
- The scheduled time for your surgery has been reserved specifically for you without interruption. Except for emergency situations, you will be charged $250 if you miss or cancel a scheduled surgery without giving 48 hours' notice, to be paid in advance before any subsequent appointment can be made.

Minor Patients

- For minor patients, the adult accompanying the patient will be responsible for payment due at the time of service. A signed release to treat may be required for unaccompanied minors.

Weight Management Program

- Please be advised that insurance plans do not cover most of our weight management program fees. Because we are unable to bill insurance companies for most of our services, our weight management program is primarily a self-pay program.
- Patients receiving weight management care will be responsible for paying **in full** before receiving services.
- The weight management fee is $150 for the initial consultation and $75 per visit thereafter.

Phone Consultation/After Hours Clinic Convenience Fee

- Phone consultations are available to established patients only and are not covered by insurance. They must be scheduled and paid for in advance at a minimum rate of $75 for the first half hour and $25 every thirty minutes thereafter.

Completion of Forms

- We charge a fee to complete various forms. For FMLA forms, there is a $50 fee. Please be aware that this fee is not covered by insurance companies.

Medical Records

We charge for copying any and all type of medical records. This charge will be paid in advance along with a written request for the copy of medical records. Please be aware that this fee is not covered by insurance companies. Rates are as follows:

- $25 for the first 20 pages and $0.50 for every page thereafter. Actual costs of mailing not included.
- $8 per copy for films or diagnostic imaging studies
- If an affidavit is requested to certify that the information is the true and correct copy of the records, a fee up to $15 may be charged for executing the affidavit. The fee **may not** include costs associated with searching for and retrieving the requested information.
- The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician **within 15 business days** after the date of receipt of the request and reasonable fees for furnishing the information.
- The copying of medical receipts/statements will carry an administrative charge of $50.

Cash Discounts

As a courtesy, cash discounts can be offered on most services to uninsured patients who pay in full **at the time of service.** Please be aware:

- Some services such as weight management fees, phone consultations and After Hours Clinic convenience fees may not be discounted.

Payment Plans

- We understand that healthcare expenses can be a financial burden. We are willing to work with you to establish a reasonable payment plan. The Heard Clinic will document approved payment plans in writing.
- Please be aware that certain specialized services are also eligible for medical financing. Our financial staff is available to answer any questions you may have.

Medication Loans

- The loaning of medications by The Heard Clinic is permitted only in cases where a medical reason exists to acquire the medication sooner than possible by normal purchasing procedures. A credit card will be obtained at the time medications are loaned and will be charged should the medications not be replaced.
- Please be aware that **new** treatments will not be permitted until the medications are replaced. NO exceptions will be made.

Returned Checks

If a check is returned for insufficient funds or closed account, or payment is stopped, your account will be charged a $40 fee. Patients who do not reconcile their account will no longer have the option to pay by check.

Past Due Accounts

If your account becomes past due, we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed as a patient from The Heard Clinic for non-payment.

Termination:

We reserve the right to terminate the physician-patient relationship for:

- Frequent no-shows or last minute cancellations. People who continually fail to keep appointments prevent us from being able to offer those appointment slots to others.
- Repeated abuse of our office policies.
- Past due accounts when the patient's family does not make a good faith effort to meet a payment schedule.

THE HEARD CLINIC

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Advanced Reproductive Medicine

Signature Page

Thank you for reviewing our financial policy. We appreciate you choosing The Heard Clinic and look forward to serving you and your family.

I have read and received a copy of the above financial policy of the Heard Clinic. I have understood this policy completely and I accept the terms listed above.

Print Name _____ Date _____

Signature _____ Witness _____

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES: Patient/Legal Representative: _____

Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ **Date:** _____