

NW FERTILITY CENTER
Fax 503 227-5452

Patient _____ Date _____
Last First Middle Intl. Name you go by

Address _____
No. & Street City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ Patient SS # _____ Marital Status _____

Patient's Employer _____

Spouse Name _____
Last First Middle Init. Name you go by

Work Phone _____ Cell Phone _____ Birthdate _____ Age _____

Spouse's Employer _____ Spouse's SS # _____

INSURANCE CO. (Primary) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID# _____ Group _____

INSURANCE CO. (Secondary) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID# _____ Group _____

DOES YOUR INSURANCE COVER FERTILITY SERVICES? _____

How did you hear about our Center?

- Referral by Physician _____
- Friend, another patient _____
- Yellow pages, internet/website _____

EMERGENCY CONTACT:

(Other than spouse)

Name: _____

Phone: _____

YOUR E-MAIL ADDRESS: _____

Pharmacy Name and Phone Number _____

I acknowledge that I am responsible for all charges. If it becomes necessary to involve an outside entity to collect on this account, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information to secure payment of benefits.

Signature _____ Date _____

NW FERTILITY CENTER

**Patient Consent for Use and Disclosure
Of Protected Health Information (HIPAA)**

I hereby give my consent for NW Fertility Center to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (NW Fertility Center’s Notice of Privacy Practices provides a more complete description of such disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. NW Fertility Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NW Fertility Center’s Privacy Officer at 1750 SW Harbor Way, Ste 200, Portland, OR 97201.

With this consent, NW Fertility Center may **call** my home or alternative location and leave a message on voice mail, or in person, in reference to any items that assist in the practice carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, NW Fertility Center may **mail** to my home or other alternative location any items that assist in the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards, and patient statements.

With this consent, NW Fertility Center may **email** to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appoint reminders, and test results.

I have the right to request that NW Fertility Center restrict how it uses or discloses my personal health information to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent, in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign, or later revoke this consent, NW Fertility Center may decline to provide treatment to me.

Printed Name of Patient

Printed Name of Spouse

Signature of Patient or Legal Guardian

Signature of Spouse

Date