DVIF&G
Delaware Valley Institute of Fertility & Genetics
Success Through Assisted Reproductive Technology START
6000 Sagemore Drive, Suite 6102, Marlton, NJ 08053 • 856-988-0072 • Fax: 856-988-0056

Consent Form

During my evaluation and treatment at Delaware Valley Institute of Fertility & Genetics (DVIF&G), a number of procedures, laboratory tests, toxicology/ genetic screening and/or testing, X-rays, ultrasounds, and clinical examinations will be performed. Information collected through those tests is essential for diagnosis and treatment or for exclusion of any underlying medical problem(s) or condition(s). This information will become my permanent medical record. The authorized physician(s) and staff of DVIF&G and I will have access to this record and only with my consent will this information be made available to any authorized party.

_____ (Initials)

During your evaluation at DVIF&G, genetic tests may be ordered. Genetic conditions can occur spontaneously so that you are the only one in your family that is affected. However, you may inherit the condition from your parents. If your genetic test is abnormal, **YOU HAVE TO NOTIFY** your family members, as they may have the same condition. Some of the genetically inherited conditions may require further evaluation and possible treatment to safeguard health and well being.

_____ (Initials)

I understand that my insurance carrier and its lawfully designated representatives or other state or federal agencies, as the law provides, can obtain and review my medical record without any previous authorization by either my physician or me. I also understand that data collected through my evaluation and treatment will be used separately and collectively with those obtained from other patients and without any personal identification of any kind for quality assurance, quality control, clinical research, evaluation of effectiveness of treatment, assessment of treatment methods, and the like, as deemed necessary. Any biological samples, such as urine, blood, serum, and/or semen obtained in the course of my evaluation and treatment, after the intended biochemical or biological measurement are completed, will be disposed of according to the rules and regulations provided by OSHA for medical, infectious and biohazardous waste or will be used separately and collectively with those obtained from other patients and without any personal identification of any kind for quality assurance, quality control, clinical research, evaluation of effectiveness of treatment, assessment of treatment methods, and the like, as deemed necessary. A complete copy of the Notice of Privacy Practice is available on our website or may be obtained upon request.

_____ (initials)

I understand that my treatment may require blood work. These labs may consist of infectious labs including, but not limited to, Hepatitis, HIV, RPR, and any genetic testing which may include, but not limited to, Karyotype and Cystic Fibrosis. I agree to the insertion of a peripheral blood collection device by a trained professional. I realize that this is an invasive procedure and has certain risks such as infection, bruising, vein inflammation, and nerve damage.

_____(initials)

I am not legally married to someone other than the person with whom I am seeking fertility treatment in your office. I understand that If I am married to someone else, I will be required to obtain additional legal documentation prior to fertility treatments, and all ongoing treatment will be suspended.

_____(initials)

I agree that upon making an appointment with DVIF&G, I will take responsibility to keep that appointment. If I am unable to keep the appointment, I will call DVIF&G no later than 24 hours prior to the appointment to cancel and reschedule the appointment. If I provide DVIF&G with less than 24 hours notice of a cancellation, they have the right to charge me $50.00 for the empty time slot. _____ (initials)

I, _____, ☐ **do** give / ☐ **do not** give Delaware Valley Institute of Fertility & Genetics permission to speak with _____ about my test results.

_____ Signature

I, _____, ☐ **do** give / ☐ **do not** give Delaware Valley Institute of Fertility & Genetics permission to share my medical information with any of my referring physicians.

_____ Signature

I hereby certify that I have read and understand the information included in this consent form.

_____ Print Name

_____ Print Name

_____ Patient Signature Date

_____ Witness Signature Date