福利分配和同意使用和透露健康信息
ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

隐私条例通知：

通过此表，您将获得我们【隐私条例通知】的副本，其中详细说明，我们将如何使用和透露您个人的健康信息，包括治疗，付款和医疗保健目的使用和透露。 本声明还解释对您健康信息拥有的重要权利。波士顿试管婴儿中心和新英格兰试管婴儿中心（以下简称“中心”）保留随时更改其隐私声明的权利，但您始终可以根据要求或访问我们的网站获得最新副本：www.bostonivf.com.

NOTICE OF PRIVACY PRACTICES:

With this Form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. Boston IVF Inc. and IVF New England (hereinafter referred to as the “Practice”) reserves the right to change its Privacy Notice at any time but you may always obtain a current copy upon request or by going to our website: www.bostonivf.com.

信息的使用和透露：

如我们的【隐私条例通知】所述，我们出于各种治疗，付款和医疗保健目的使用和透露您个人的健康信息。 作为您治疗的一部分，我们期盼您允许我们，无保留地与您和您的配偶，分享所有与治疗有关的健康信息。 除非您在下面提供的空格中指定何种限制，否则，表示您同意，在接受我们的常规治疗时，向您的配偶透露与治疗相关的信息。**您可能会通过邮件，电话，传真，电子邮箱和/或互联网公开您的信息，这对于中心完成这些目的可能是必要的。**如果您的健康信息，包含州或联邦法律的任何特权或需其他保护的信息，系统将要求您签署特定的授权以发布此信息。

USE AND DISCLOSURE OF INFORMATION:

As described in our Notice of Privacy Practices, we will use and disclosure your individually identifiable health information for a variety of treatment, payment and health care operations purposes. As part of your treatment, we expect that you will want and allow us to share, without restriction, all of your health information related to the treatment of you and your partner. Unless you specify any restrictions in the space provided below, you are hereby consenting to such treatment-related disclosures to your reproductive partner while you are undergoing treatment by our Practice. **The disclosure of your information may be made via mail, telephone, fax, e-mail, and/or Internet as may be necessary for the Practice to complete these purposes**. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

福利分配：

考虑到提供的服务和治疗，我特此将所有健康保险分配，转让并移交给该中心。我在此指示, 我的保险公司支付, 由波士顿试管婴儿中心和新英格兰试管婴儿中心, 提供的治疗和测试的所有款项，这些款项将直接发送给该中心。

ASSIGNMENT OF BENEFITS:

In consideration for services and treatment rendered, I hereby assign, transfer, and set over onto the Practice all health insurance. I hereby direct my insurance company to make all payments for treatment and testing provided by Boston IVF Inc. and IVF New England to be sent directly to the Practice.

使用和透露限制：

如我们的隐私条例通知中所述，您有权要求中心如何用于治疗，付款和医疗保健操作，及向家庭成员或朋友透露使用目的和透露您的健康信息。您还有权要求我们把含有您的健康信息，发送到您选择的地址，或者我们以某种方式与您通信（例如，不要在我的家用答录机上留言）。尽管我们不需要批准任何此类请求，但您可以指出所需的限制或说明：

RESTRICTIONS ON USES AND DISCLOSURES:

As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations, and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you in a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions:

Boston IVF

福利分配和同意使用和透露健康信息
ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

我特此同意本中心及其专业人员，员工和代理商，使用和透露我上述的个人健康信息。特此我确认，我已收到隐私条例上的条例通知。我了解，如果我有其他问题或有任何投诉，可以致电781-434-6500与隐私业务官联系。我特此宣布中心，其专业人员，员工和代理商，所有责任是出于治疗，付款和运营目的使用和透露我的健康信息。我了解，我可以书面形式撤销该此意书，除非业务部门已经在采取此同意的行动。我也了解，如果我撤销此同意书，则中心可能会拒绝为我提供进一步的治疗。我也了解，此同意书授权该中心，根据其隐私声明使用和透露我的病历中记录的所有过去信息。

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at 781-434-6500 if I have further questions or any complaints. I hereby release Practice, its professionals, employees, and agents, from all liability arising from the use and disclosure of my health information for treatment, payment, and operations purposes. I understand that I may revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

_____ _____

病人/监护人签名 关系

Patient/Guardian Signature Relationship

如果无法获得患者书面确认同意隐私条例
TO BE FILLED OUT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICER OF PRIVACY PRACTICES FROM PATIENT

我试图从上述指定患者处获得书面确认，收到隐私条例上的条例通知，但由于以下原因而无法：
I attempted to obtain a written acknowledgment of receipt of the Practice Notice of Privacy Practices from the above named patient, but was unable to because:

选择合适答案 Check the appropriate box:

☐ 患者拒绝签署书面确认书。
Patient declined to sign the Written Acknowledgment.

☐ 其他（详细说明）
Other [specify details] _____

经手人 日期：2021 年 4 月 6 日

By: ---------- Date: April 12, 2021

了解您的保险福利
UNDERSTANDING YOUR INSURANCE BENEFITS

欢迎来到波士顿试管婴儿中心。我们知道, 保险和财务事项可能较为复杂。此文件主要概述在波士顿试管婴儿中心，接受服务时需要了解保险和财务上的重要信息。请仔细阅读此文件，因为您在此表单上签名，表示您已阅读并理解该信息。作为波士顿试管婴儿中心的患者，本文件将在您，作为波士顿试管婴儿中心的患者期间内有效。

Welcome to Boston IVF. We know that insurance and financial matters can be complicated. This document is designed to outline important insurance and financial information that you need to know while receiving services at Boston IVF. Please read this document carefully as your signature on this form indicates you have read and understand the information. This document will be valid during your entire time as a patient here at Boston IVF.

- 请联系您的保险公司，因为您有责任获得您不孕补助福利。您保险公司客服部代表及雇主人力资源部将帮助您了解您的医疗计划，**保险涵盖和没有涵盖的内容。**
  Please contact your insurance company as it is **your** responsibility to obtain your infertility benefits. Your insurance company's customer service representatives, as well as your employer's benefits personnel will help you to understand your plan**, what it covers, and what it does not.**
- 您的保险公司可能会要求您看诊时需要家庭医生转诊。您有责任取得这些转诊。如果您无法从您的家庭医生获得转诊批准，则需要自费。
  Your insurance company may require referrals from your primary care physician for your visits. It is your responsibility to obtain these referrals. If you are not able to obtain a referral from your primary care physician you will be charged for your visit(s).
- 如果您的保险计划有治疗费用的限额，您有责任追踪保险支付的费用。一旦达到最高限额，您将支付所有对您提供的服务费用。
  If your insurance plan imposes a dollar limit on your treatment, you are responsible for keeping track of the money paid by your insurance. Once you have met this dollar maximum, you will be responsible for the cost of services that are provided to you.
- 如果您的保险有任何变更，请**立马**通知我们。在治疗期间，如果在治疗期间您的承保范围终止，您将承担因保险失效所需支付费用的财务责任。因为保险公司有事先批准的要求，如果您在进行治疗周期时，更改保险计划，则周期可能会延迟或取消，并且您可能需要承担该治疗周期的费用。 如果您进行任何未经保险公司批准的治疗，您将自行负担这些费用。
  Please notify us **immediately** of any changes to your insurance. If your coverage terminates while you are undergoing treatment, you will be financially responsible for charges incurred during your lapse in coverage. Due to the pre-authorization requirements of the insurance companies, if you change insurance plans while undergoing a treatment cycle, your cycle may be delayed or cancelled and you may be responsible for the cost of that treatment cycle. If you proceed with any treatment that has not been approved by your insurance company, you will be responsible for those charges.

- 许多患者选择我们中心冷冻精子和/或胚胎。 这可能或不在您保险计划中涵盖的福利。请与您的保险公司联系，以确定这些服务是在承保范围。
  Many patients choose to freeze sperm and/or embryos at our facility. This may or may not be a covered benefit under your plan. Please check with your insurance company to determine if these services are a covered benefit for you.
- 冷冻胚胎和冷冻精子的年度保存费，不在保险给付范围。请与您的财务顾问联系，以了解这些服务的目前价格。
  There are annual storage charges for frozen embryos as well as frozen sperm that are not covered by insurance. Contact your financial counselor for our current prices for these services.
- 如果您要取消看诊，需在 **48 小时内通知**。 如果您没有在 48 小时内，通知取消您的约诊，或者您在约诊中未出现，您有责任支付，延迟取消或不来的费用，最高不超过全额的看诊费。
  We require 48-hour notice if you are canceling your appointment. If you do not cancel your appointment with a **48 hour notice** or if you do not appear for your appointment you will be responsible for a late cancellation or no show fee of up to the full cost of the visit.
- 所有的费用，需在提供服务之前缴清款项。如有欠款，您有责任支付所有收款费用，包含律师费。
  All charges on your account are due prior to services being rendered. In the event your account becomes delinquent, you will be responsible for all collection costs including any attorney fees.

信用政策：我们的政策是，服务是需付费。如果您有保险，而您的保险计划有包含不孕范围，我们将向保险公司申请给付。所有扣除额，分担额或费用的百分比必须在服务时支付。如果保险拒绝给付，则在所有服务开始前，需缴清全额款项。

CREDIT POLICY: It is our policy that payment is required at the time of service. If you have insurance and your insurance plan provides coverage for infertility services, we will bill them for you. All deductibles, co-pays, or percentages of fees must be paid at the time of service. If insurance is denied, payment in full is required prior to commencement of any services.

了解您的保险给付
UNDERSTANDING YOUR INSURANCE BENEFITS

保险给付的同意书：我在此授权代表我，直接向波士顿试管婴儿中心，支付所有保险索赔。

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize that payment of all insurance claims on my behalf be made directly to Boston IVF.

信息发布：我在此授权波士顿试管婴儿中心，向我的保险公司申请，处理我的保险索赔所需的任何医疗信息，包括诊断及就诊记录。

RELEASE OF INFORMATION: I hereby authorize Boston IVF to release to my insurance company, any medical information, including diagnosis and records of treatment, necessary to process my insurance claims.

财务责任协议：我了解，如果我没有保险，我将承担所有在波士顿试管婴儿中心，收到服务的财务责任。我也了解，如果我有保险，我将对我的保险公司未承保的任何金额承担财务责任。**在我的疗程中，可能需要超声波和血液检查。我了解，如果我使用，波士顿试管婴儿中心和新英格兰试管婴儿中心以外的中心，我将负责所有费用。我了解，个人和保险信息有任何更改，我必须立即通知波士顿试管婴儿中心和新英格兰试管婴儿中心，并在以下签名来表明，我在此表格上查看的信息是正确的。**如不提供此信息，将导致我个人必须承担财务责任，且立即支付我账户上的款项。如有欠款，我同意支付与追收与欠款相关的所有费用，其中可能包括合理的催收和律师费。

AGREEMENT OF FINANCIAL RESPONSIBILITY: I understand that if I do not have insurance I am financially responsible to Boston IVF for any services I receive. I also understand that if I have insurance coverage, I will be financially responsible for any amount not covered by my insurance company. **During my treatment monitoring with ultrasounds and blood work may be required. I understand that if I use a monitoring site other than one of the Boston IVF and IVF New England centers I will be responsible for all charges incurred. I understand that I must provide Boston IVF and IVF New England with any changes to my personal and insurance information immediately and by signing below indicate that the information I reviewed on this form is correct.** Failure to provide this information will result in my account becoming my sole financial responsibility, payable immediately. In the event that this account becomes delinquent, I agree to pay all costs associated with collecting this debt, which may include reasonable collections and attorney's fees.

以下我的签名，表示我已阅读并理解本文档中提供的信息。
MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS DOCUMENT.

_____ _____

签名 Signature 日期 Date

_____

正楷全名 Print Name

波士顿试管婴儿中心 Boston IVF, LLC
患者权利通知 NOTICE OF PATIENT RIGHTS

在此健康中心的每个患者应具有以下权利：
EVERY PATIENT OF THIS HEALTH CENTER SHALL HAVE THE FOLLOWING RIGHTS:

1. 有权要求询问负责医疗的医师或其他负责人员（如果有）姓名和专长。
   The right to ask the name and specialty, if any, of the physician(s) or other persons responsible for your care and the coordination of your care.

2. 在法律规定的范围内对所有记录和通讯保密。
   Confidentiality of all records and communications to the extent provided by law.

3. 在机构能力范围内，对所有合理的要求做出迅速，充分的回应。
   To have all reasonable requests responded to promptly and adequately within the capacity of the facility.

4. 根据要求，如果机构与其他任何健康医疗机构，或教育机构间有关联，则他/她的照顾相关，会获得说明。
   Upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution in so far as said relationship relates to his/her care of treatment.

5. 根据要求，从机构指定的人那里，可收到机构提供与财务辅助相关的任何信息。
   Upon request, to receive, from a person designated by the facility, any information which the facility has available, relative to financial assistance.

6. 根据要求，检查他/她的病历并收到病历复印件，复印费将按照联邦政府的规定收取。
   Upon request, to inspect his/her medical records and to receive a copy of the medical records, the copying fee will be in accordance to that set by the federal government.

7. 拒绝学生或任何其他设施工作人员的检查，观察或治疗，而不会影响获得精神科，心理或其他医疗护理或护理的机会。
   To refuse examination, observation, or treatment, by students, or any other facility staff, without jeopardizing access to psychiatric, psychological, or other medical care or attention.

8. 在以教学或信息为目的而非治疗性的情况下，拒绝充当研究对象和任何医疗或检查。
   To refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.

9. 在医疗机构能力所及的范围内，对治疗或其他护理的保有隐私。
   To privacy during medical treatment or other rendering of care within the capacity of the facility.

10. 在紧急情况下，尽量治疗来挽救生命，而不会因经济状况或付款来源而受到歧视，也不会事先讨论付款来源而延误治疗。

To prompt life saving treatment in an emergency without discrimination due to economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment.

11. 在法律规定的范围内，知情同意。
    To informed consent to the extent provided by law.

12. 如果有其他合格的专业者，则应要求更改专业者。
    To change providers upon request, if other qualified providers are available.

13. 根据要求，患者有权接收由其医疗机构提交给任何第三方的详细账单或其他费用表的副本，并将该详细账单或声明的副本，发送给患者的主治医生或住院医生。
    Upon request, patient has the right to receive a copy of an itemized bill or other statement of charges submitted to any third party, by the facility for their care, and to have a copy of said itemized bill or statement, sent to the attending physician of the patient or resident upon request.

14. 不受任何的歧视，不受任何的虐待和/或骚扰。
    To be free from any form of discrimination and to be free of all forms of abuse and/or harassment.

15. 患者正式向沃尔瑟姆手术室内提出投诉某位特定医生。医师的投诉会向医学注册委员会提出，地址麻州韦克菲尔德市哈佛大学磨坊广场 200 号邮编 01880, 办公室 330 号，或消费者热线 1-800-377-0550。
    To file a formal patient complaint against a specific physician at the Surgery Center of Waltham. Physician complaints are filed with Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 or consumer line 1-800-377-0550.

16. 患者可以透过其代言人或管理者，以提出投诉或申诉，而不必担心遭到报复。如果申诉仍未得到满意的解决，您有权直接通过以下地址与 AAAHC（门诊手术室内认证协会）联系：1-847-853-6060 或麻州公共卫生部(DPH)：麻州公共卫生部，卫生保健质量司，投诉单位，地址：麻州波士顿市西大街 10 号 5 楼 邮编 02111。咨询热线：1-800-462-5540。
    Patient may speak with a Patient Advocate or Manager to lodge a complaint or grievance without fear of reprisal. If grievances are not resolved to your satisfaction, you have the right to contact the AAAHC (Accreditation Association of Ambulatory Surgery Centers) at 1-847-853-6060 or the Massachusetts Department of Public Health (DPH) directly at the following location: Commonwealth of Massachusetts, Department of Public Health, Division of Health Care Quality, Complaint Unit, 10 West Street, 5th Floor, Boston, MA 02111. Hotline: 1-800-462-5540.

17. 提交指定代理人的权利，您可以指定一位医疗照顾代理人。(麻州执法，第 210D 章)。表格可应要求提供。请注意，根据麻州法律，如果发生紧急医疗情况，您的指定代理人将无效。如果在沃爾瑟姆外科中心期间遇到严重的医疗事件，您将获得紧急医疗护理，并且您的指定代理人将陪伴您前往紧急就难机构。
    The right to file an Advanced Directive, allowing you to appoint a health care proxy. (Mass. General Law, Chapter 210D). Forms are available upon request. Please note that under Massachusetts Law, your Advanced Directive will not be effective in the event of a medical emergency. **If you suffer a serious medical event while at the SCW, you will receive emergency medical care and your Advanced Directive will accompany you to the emergency receiving facility.**

18. 如果根据适用的州健康与安全法，由具有管辖权的法院裁定患者无能为力，则患者的权利应由根据州法律任命的代表患者行事的人行使。如果州法院未裁定患者无能为力，则患者根据州法律指定的任何法定代表人，都可以在州法律允许的范围内行使患者的权利。
If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient shall be exercised by the person appointed under State law to act on the patients' behalf. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

19. 每位患者均有权获得提供患者医疗的医生执行长名单。
Each patient has the right to receive a listing of Physician Shareholders providing patient care.

现任执行长如下：
Current shareholders are listed below:

麦克 欧博医生
Dr. Michael Alper

波士顿试管婴儿中心 Boston IVF, LLC
患者权利通知 NOTICE OF PATIENT RIGHTS

您对本健康中心的责任是
YOUR RESPONSIBILITIES TO THIS HEALTH CENTER ARE:

1. 提供有关病史，住院情况和当前健康问题的准确和完整的信息。
   To provide accurate and complete information regarding medical history, hospitalizations, and current health concerns.

2. 参与和配合您的治疗，并遵循主治医师的指导和其他医疗专业人员推荐的治疗计划。
   To participate and collaborate in your treatment, and to follow treatment plans recommended by physicians and other health professionals working under the attending physician's direction.

3. 提供准确和完整的财务信息，并与医疗中心合作，以确保履行与您医疗有关的财务义务。
   To provide accurate and complete financial information and work with the medical center to ensure that financial obligations related to your care are met.

4. 对保险未涵盖的任何费用，承担个人财务责任。
   To accept personal financial responsibility for any charges not covered by insurance.

5. 根据服务提供者的指示，提供负责任的成年人提供交通工具回家，并留在您身边 如放电说明所示。
   To provide a responsible adult to provide transportation home, and to remain with you, as directed by the provider or
   as indicated on discharge instructions.

6. 尊重所有医疗专业人员，工作人员，其他患者和访客为。 破坏性，暴力或威胁性行为可能会导致终止。
   To behave respectfully toward all health care professionals and staff, as well as other patients and visitors.
   Disruptive, violent, or threatening behavior may result in termination of care.

如果我被转到医院或急诊室，我将授予波士顿试管婴儿的指定代表，以申请有关我的医疗信息。 **是/否**
If I am transferred to a Hospital or Emergency Room, I give a designated representative of Boston IVF permission to request information about my care. **Yes / No**

我已阅读并查看上述信息，有机会获得更多信息并提出问题。
I have read and reviewed the above information and had to opportunity to obtain more information and ask questions.

_____ _____

病人同意Patient Acknowledgement **日期Date**

电子邮箱件通信同意书（波士顿试管婴儿中心版）
E-MAIL CORRESPONDENCE CONSENT (eIVF version)

适合使用电子邮箱通讯目的
APPROPRIATE PURPOSE FOR E-MAIL CORRESPONDENCE

电子邮箱只适用于询问信息，非紧急问题和研究相关的沟通。**无法在紧急情况或关乎您医疗健康的敏感话题时刻下使用。**在此敏感时刻，有任何问题或疑虑，请直接打电话与您的医生联系。 波士顿试管婴儿中心会在上班时间，查看电子邮箱。可能在次日回复电子邮件。如果您健康方面突然或严重改变，或有事急需要即刻回复，请立马联系 911。
E-mail may be used to request information, non-urgent questions and communicate about research studies. **It is NOT to be used for emergencies or for time sensitive issues related to your medical care.** Please contact your physician by phone with questions or concerns that are time sensitive. E-mail correspondence is reviewed by Boston IVF during regular business office hours. Reply to e-mail may occur on the following business day. If you experience a sudden or severe change in your health, or otherwise need an immediate response, please contact 911 immediately.

患者责任
PATIENT RESPONSIBILITY

更改您所登记的电子邮箱时，须向挂号处或您医生行政助理提出请求。您的电子邮箱通讯一旦变更，将会记录在您的医疗记录中。您可以随时取消同意使用电子邮箱，作为书面形式的沟通，除非此做法已经被执行过。
Requests to change your e-mail address on record must be made to our Registration Department or your physician's Administrative Assistant. Changes made in regards to your e-mail correspondence will be documented in your medical record. You may revoke consent to use e-mail as a form of correspondence in writing at any time, except to the extent the practice has already made disclosures.

隐私建议
PRIVACY RECOMMENDATIONS

我们无法，且不保证通过互联网发送的任何讯息的隐私或安全性。通过互联网发送的电子邮箱有可能被其他人拦截和读取。此外，您应该清楚了解，如果您使用雇主提供的电子邮箱，您的雇主可能会查看，任何在雇主系统上发送的电子邮件。
We cannot and do not guarantee the privacy or security of any messages being sent over the Internet.
There is the potential that e-mail sent over the Internet can be intercepted and read by others. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, your employer may view any e-mail sent on your employer's system.

电子邮箱使用确认
E-MAIL USE ACKNOWLEDGEMENT

我已被告知并了解，使用电子邮箱作为一种通信方式所涉及的风险和需要。我理解，通过电子邮箱发送电子传输时，可承担个人身份健康信息的机密性。我同意上述所列的条款，在此，我自愿接受以电子邮箱作为与波士顿试管婴儿中心的医生和工作人员沟通的一种方式。
I have been informed of and understand the risks and requirements involved with using e-mail as a form of correspondence. I understand that the confidentiality of my individually identifiable health information may be compromised when sent through electronic transmission via e-mail. I agree to the terms listed above, and I hereby voluntarily accept e-mail as one form of communication with my physician and staff at Boston IVF.

_____ _____

患者签名/监护人签名
Patient/Guardian Signature

日期
Date

_____ _____/_____/_____

正楷全名
Print Name

出生日期
Date of Birth