1148 5th Ave Suite 1C New York, NY 10128 | (212) 661-7177 | info@indianeggdonors.com

General Consent for Evaluation and Treatment

General Consent for Treatment and Participation in Care

I Have Voluntarily Presented to DGA and authorized its Providers and Other Healthcare Professionals to Provide Fertility Injection Administration.

Patient Responsibilities

I understand that I must be an **active participant** in my care. This includes:

- Providing complete, accurate, and up-to-date information to DGA, including my medical history, any medications or supplements I am taking, and any conditions that may interfere with my care (e.g., travel, lifestyle changes).
- Sharing all relevant records from other providers or facilities, including but not limited to:
    - Results of prior genetic testing.
    - Details of significant medical conditions.
    - Information on previous pregnancies and fertility treatments.

I am responsible for:

- **Knowing my test results**: If I do not receive results for any testing performed or do not fully understand their implications, it is my responsibility to contact my DGA healthcare team.
- **Attending all scheduled appointments** and following the instructions of my healthcare team. I understand that failure to comply may negatively affect my care and could result in medical complications.

Rights and Refusals

I understand that I have the right to refuse any particular exam, test, treatment, or other intervention. However, I acknowledge that refusal may limit DGA's ability to provide care or complete treatment plans.

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Use of Trainees and Observers

understand that appropriately supervised students, residents, and/or trainees may observe, participate, and assist in my care unless I expressly object to their involvement.

Environment and Safety

DGA provides a **safe, professional, and respectful environment** for providers, staff, and patients.

- I understand that sensitive examinations and procedures will be clearly explained, undertaken only with my consent, and performed with the minimum necessary physical contact.
- A chaperone will be provided for certain services or upon my request for any service.
- DGA maintains a **zero-tolerance policy** for inappropriate, discriminatory, and/or threatening behavior, and I understand that such conduct will not be tolerated under any circumstances.

Consent to Data Transparency

I understand that the **Open Payments Database** is a federal tool that provides transparency regarding payments made by drug and device companies to physicians and teaching hospitals. Information can be accessed at: Open Payments Data - CMS.

General Acknowledgment

I have read and understand this document in its entirety, and any questions or concerns I have raised have been addressed to my satisfaction. I acknowledge that I am fully responsible for adhering to the terms outlined herein to ensure the best possible care and outcomes.

By clicking "I consent", I agree and acknowledge that I have Read and understand the information provided above.

(I consent icon)

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