cliniqueovo

Our *family* helping yours

CONSENT FORM

NON RESIDENT AGREEMENT

Complete address **mandatory**:

Street number _____

City, province _____, Postal code _____

GOVERNING LAW AND JURISDICTION AGREEMENT

To: clinique ovo and the doctors practising there (collectively, the "Clinic")

Date: _____

RE: Confirmation of Quebec (the "Province") as Governing Law and Jurisdiction

GOVERNING LAW

I hereby agree that:

1. all aspects of the relationship between me and the Clinic, as well as its agents, delegates, employees, and any other independent health care practitioners providing medical or other health care and treatment to me, or in association with the Clinic, including without limitation any medical or other health care and treatment provided to me; and

2. the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement, shall be governed by and construed in accordance with the laws of the Province and the laws of Canada applicable therein.

JURISDICTION

I hereby acknowledge that the medical or other health care and treatment I receive from the Clinic will be provided in the Province, and that the courts of the Province shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other health care and treatment, or from any other aspect of my relationship to the Clinic.

I hereby (i) waive any objection to the laying of venue of any such action or proceeding in Province courts, (ii) waive and agree not to plead or to make, any claim that any such action or proceeding brought in the Province courts has been brought in an improper or otherwise inconvenient forum, and (iii) acknowledge that the Clinic does not attorn to any jurisdiction outside of Canada in respect of any aspect of my relationship with it and there shall be no presumption of jurisdiction in respect of any jurisdiction, even if I am a resident in such jurisdiction, other than the courts of the Province.

Dated the date first written above.

I/we have been given sufficient time to read and understand the content of this document and I/we have had the opportunity to ask any questions that I/we may have and obtain appropriate information before signing. I/we have been given all the relevant details of the treatment and have had all the options explained to me/us.

PATIENT 1 SIGNATURE

Signed on the _____ day of the month of _____, in the year _____ at _____ (city).
Signature of patient 1

IF TREATED AS A SINGLE PATIENT

☐ I confirm that I will be treated as a single patient. **ovo fertility inc.** will not be involved in any legal dispute between me and a partner that I have not disclosed to the clinic.

Signed on the _____ day of the month of _____, in the year _____ at _____ (city).
Signature of patient 1

WITNESS STATEMENT
The witness cannot be the partner involved in the treatment

I have personally verified the identity of patient 1 with the following identification document (please check one of the choices below). Patient 1 signed this consent in my presence.

☐	Patient 1's health insurance card
☐	Patient 1's driver's licence
☐	Patient 1's passport number
OR	
☐	I know patient 1 personally

Name of witness	
Address	

Signed on the _____ day of the month of _____, in the year _____ at _____ (city).
Signature of witness

PATIENT 2 SIGNATURE

☐ I am the partner of _____, and I consent to the treatment described above, including all options chosen.

Signed on the _____ day of the month of _____, in the year _____ at _____ (city).
Signature of patient 2

WITNESS STATEMENT – The witness cannot be the partner involved in the treatment

I have personally verified the identity of patient 2 with the following identification document (please check one of the choices below). Patient 2 signed this consent in my presence. The witness cannot be the partner involved in the treatment

☐	Patient 2's health insurance card
☐	Patient 2's driver's licence
☐	Patient 2's passport number
OR	
☐	I know patient 2 personally

Name of witness	
Address	

Signed on the _____ day of the month of _____, in the year _____ at _____ (city).
Signature of witness

Please return this completed form to us at **consentements@cliniqueovo.com**