

THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES
CONSENT FOR CRYOPRESERVATION AND STORAGE OF EMBRYOS

Female Name: _____ Female ID# _____

Partner Name: _____ Partner ID# _____

Address: _____

We (I), the undersigned, request, authorize and consent to the cryopreservation (freezing) and/or storage of embryos by The Center for Advanced Reproductive Services, PC (The Center), and, as appropriate, its employees, contractors, and consultants and authorized agents.

If numerous eggs are retrieved during our (my) cycle, the number of eggs exposed to sperm will be decided by us (me) and our (my) doctor. If we (I) elect to expose most or all of our (my) eggs to sperm in order to develop as many embryos as possible, any viable embryos not transferred to the uterus will be frozen (cryopreserved). We (I) understand that execution of this consent does not guarantee that embryos will be cryopreserved and the number of embryos frozen will be at the discretion of The Center staff, based upon the embryo quality and our (my) choice in consultation with our (my) physician. We (I) understand that we (I) will be notified if embryos are cryopreserved.

If a pregnancy does not occur as a result of the initial embryo transfer, if we (I) have a miscarriage, or if a successful pregnancy does occur but we (I) subsequently desire another child, the frozen embryos will be available to us (me) for thawing and transfer during a subsequent menstrual cycle. This procedure may be repeated until all the frozen embryos have been utilized. We (I) understand and agree that it is a policy of The Center to store our (my) embryos for a maximum time period of five (5) years.

On average, over 70% of embryos survive the freezing and thawing process, so the number of embryos that are viable after thawing may be less than the number of embryos frozen. It is possible that none of the embryos will survive the freezing and thawing process. There is no guarantee that the transfer of frozen embryos will result in a successful pregnancy. We (I) have discussed The Center's pregnancy rates for frozen embryo transfers with our (my) doctor. We (I) also understand that it does not appear that the utilization of frozen embryos increases our (my) risk of having a child with a birth defect above the incidence observed in the spontaneously conceiving population. We (I) understand that both the cryopreservation and storage procedures involve the use of mechanical and/or electrical equipment. The Center will make all best efforts to maintain and monitor this equipment and provide backup in the event of an equipment failure. However, despite their best efforts, equipment failure may result in the damage or loss of one or more embryos. We (I) understand and agree that The Center shall be responsible only for acts of negligence on its part and the part of its employees, contractors, and consultants and authorized agents.

At any time during the storage of our (my) embryos, when our (my) treatment at The Center is completed, at the end of five years of storage or if The Center closes (whichever comes first) we (I) understand that we (I) have several options regarding our (my) frozen embryos in storage at The Center including:

1. Donation of the embryos to another couple or woman for their (her) own attempts at pregnancy.
2. Disposal of the embryos according to American Society for Reproductive Medicine (ASRM) ethical standards.
3. Transfer of the cryopreserved embryos from the Laboratory at the Center to another fertility center, long term storage facility or research facility.

We (I) understand that each of these options requires execution of a separate written consent form signed by both of us (me) at the time that this option is exercised.

In the event of Death:

1. We (I) understand, agree and consent that if **one** of us dies (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):

- The disposition of the embryos will be left to the surviving partner.
- The embryos will be discarded according to American Society for Reproductive Medicine Ethical Guidelines.

Female's Initials _____

Partner's Initials _____

2. We (I) understand, agree and consent that if **both** of us dies or if I die, as a **single woman** (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):

- The embryos will be discarded according to American Society for Reproductive Medicine Ethical Guidelines.
- The embryos will be transported to a long term storage facility at the expense of our (my) estate.

Female's Initials _____

Partner's Initials _____

In the event that we divorce or our relationship ends:

We (I) understand, agree and consent that if **we divorce** or our relationship ends (PLEASE CHECK ONE AND BOTH PARTNERS SHOULD INITIAL):

- Custodial decisions and expenses will be left to the female partner.
- Custodial decisions and expenses will be left to the male partner.
- Custodial decisions and expenses will be left to the following designee (Same sex partners, please write in designee):

(Write in Designee Name)

- The embryos will be discarded according to American Society for Reproductive Medicine Ethical Guidelines.

Female's Initials _____

Partner's Initials _____

Additional Considerations:

We (I) understand that consents for future donation, disposal, transfer out or utilization (subsequent thaw cycle) must be signed by both individuals who signed this Cryopreservation consent, unless an applicable court decree or death of one of us supersedes it or I am a single women.

We (I) understand and agree that the Center will store these embryos for maximum period of five years, regardless of any instructions indicted above.

We (I) understand and agree that, in any situation where there is a conflict between the parties, the embryos will be moved to a long term storage facility at our (my) expense.

We (I) understand and agree that it is our (my) obligation to keep The Center informed of our (my) current address. If we (I) fail to do so or we (I) cannot be reached or do not respond to correspondence received from the Center, we (I) understand and agree that the embryos will be considered abandoned and will be discarded by the Center according to American Society for Reproductive Medicine Ethical Guidelines.

We (I) understand, agree and acknowledge that we (I) are (am) not married to individuals who are not parties to this informed consent.

Storage:

The first year of storage is included in the cryopreservation fee. At the end of the first year, we (I) will be billed quarterly, in advance, for continued storage of the embryos, up to the five year maximum storage period. If we (I) do not pay the quarterly fee in advance, we (I) will be billed accordingly:

- After the first year, Embryo storage is \$150 per quarter, billed prospectively
- All embryo storage payments are due within 30 days of receiving a statement
- After 30 days all unpaid balances roll into the collections module
- Upon the first day of entering the collections module patients will receive a phone call
- 10 days later that phone call will be followed up by a letter
- 21 days later a second phone call will be made
- 14 days later the second phone call will be followed up with a second letter
- 30 days after the second letter patients will receive a 3rd letter
- 14 days after receipt of the 3rd letter the account will be turned over to collections

We (I) understand that if two consecutive quarters of embryo storage billing roll into the collections module all subsequent quarterly embryo billings will go directly to collections until all past balances have been paid.

We (I) understand that we (I) may store our frozen embryos on site at The Center for up to 5 years in anticipation of utilizing them for subsequent fertility treatments. However, we (I) understand that The Center is not equipped to serve as a long term storage facility. After 5 years we (I) agree to review our (my) options which may include, moving the embryos to a long term storage facility, donating the embryos to another couple, donating the embryos to research or discarding the embryos. ***We (I) understand that none of the aforementioned options can be exercised without our (my) informed written consent.***

For more information on all of these options please go to The Center's website, www.uconnfertility.com > Our Programs and Services > Embryo Options.

We (I) acknowledge that, at any time during the five year maximum storage period or at the end thereof, we (I) can execute the appropriate consents to exercise any of the options listed above including moving the embryos to a long term storage facility, donating the embryos to another couple, donating the embryos to research or discarding the embryos. **We (I) understand that consents for future donation, disposal, transfer out or utilization (subsequent thaw cycle) must be signed by both individuals who signed this Cryopreservation consent, unless an applicable court decree or death of one of us supersedes it or I am a single women.**

Embryo Cryopreservation and Storage has been explained to us (me) by our (my) doctor , together with the known risks. We (I) understand the explanation that has been given to us (me). We (I) have had the opportunity to ask questions and those questions have been answered to our (my) satisfaction. Any further questions we (I) might have may be addressed to The Center staff or IVF/ET Program Director, Dr. John Nulsen at (860) 679-4580. We (I) acknowledge that IVF/ET and Embryo Cryopreservation is being performed at our (my) request and with our (my) consent.

NOTE: If TWO signatures are required, BOTH signatures must be notarized. If both partners cannot appear before the notary at the same time, then the form can be duplicated and each partner can sign separately.

_____/_____/_____
Date Female Signature

_____/_____/_____
Date Partner Signature*** **If no partner, write N/A**

Note: Notarization of BOTH signatures is required.

State of Connecticut)
)
County of _____)

On _____, before me, _____ (Insert name of

Notary), personally appeared _____ (List only the names of individuals who actually appeared for this signature), personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____ (Seal)

THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES MUST RECEIVE THIS CONSENT FORM PRIOR TO THE TRANSFER OF THE MATERIALS. THIS FORM MAY BE MAILED TO:

John Nulsen, MD, Program Director
The Center for Advanced Reproductive Medicine
Dowling South Building
263 Farmington Avenue
Farmington, CT 06030
Tel: 860-679-4580

Physician Signature:

This consent has been discussed with the patient and her partner, if any.

_____/_____/_____
Date Physician Signature