40694

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

AGREEMENT FOR CONTINUED STORAGE OF CRYOPRESERVED EMBRYOS

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

MR-844 (2-2018)

I, _____ and _____ having previously
(Patient's name) (Partner's name, if applicable*)
consented to the cryopreservation (freezing) of embryos (eggs fertilized by sperm), now enter into this *Agreement for the Continued Storage of Cryopreserved Embryos* ("Agreement") with Women & Infants Hospital of Rhode Island (WIH) pursuant to the terms detailed below.
[*All references to "Partner" in this Agreement are when "if applicable," (i.e. Patient and Partner are married and/or Partner has an ownership claim to the embryos which are the subject of this Agreement.)]

TERMS

1. Duration of Cryopreservation

All embryos that are cryopreserved pursuant to this Agreement may be frozen and stored with WIH until, at maximum, the date of the Patient's 55th birthday, ___/___/___.

2. Financial Terms

There is no charge for the first year of storage of the cryopreserved embryos. At the end of the first year, continued storage is subject to an annual storage fee. Insurance may not cover this cost and, if continued storage is desired, Patient and Partner are responsible for the storage fee. Payment is due within 60 days of billing. In the event of nonpayment, after reasonable notification of such nonpayment mailed via certified mail to the last known address for Patient and Partner, as provided to WIH by Patient and Partner, WIH reserves the right to discontinue storage and discard the embryos.

If WIH ceases to exist, Patient and Partner will be sent written notice so that arrangements can be made to have the embryos discarded or transported to another center for continued storage. If upon receipt of such notice Patient and Partner fail to make appropriate, timely arrangements for the discarding or transport of embryos (i.e. within 6 months of receipt of such notice), WIH reserves the right to discontinue storage and discard the embryos.

3. Change of Address or Status

Patient and Partner understand that it is their responsibility to notify WIH promptly in writing of any change in 1) address, 2) telephone number, 3) marital status, or 4) death of either Patient or Partner, and to notify WIH in writing if they become aware of any information that WIH should have in order to discharge its obligations under this Agreement. Patient and Partner also understand that their embryos will be considered to be abandoned if (i) they have not paid in accordance with the Financial Terms above, or (ii) the maximum storage period is approaching and, despite diligent efforts including certified mail, WIH is unable to contact them at their last known address. If Patient and Partner's embryos are considered to be abandoned, WIH reserves the right to remove the embryos from storage and discard them.

In the event of LEGAL SEPARATION or DIVORCE, the ownership and/or other rights to the cryopreserved embryos(s) will be as directed by a valid court order or court approved agreement provided to WIH by Patient and/or Partner. Until receipt of such order or agreement, both Patient and Partner shall remain equally responsible for any costs or fees associated with the continued storage of embryos.

4. **Decision Relating to Disposition of Frozen Embryos**

The parties agree that the frozen embryos are subject to Patient's and Partner's joint disposition, except as otherwise provided in this Agreement (for example, embryos may be discarded by WIH as a result of nonpayment or failure to provide updated contact information). The parties further understand and agree that all decisions about the disposition of the frozen embryos must be joint decisions by Patient and Partner, except where such disposition may be affected by applicable laws or by any court with jurisdiction over them.

Patient and Partner can, together and by mutual agreement, change any of these decisions at any time before action has been taken in reliance on such decisions, by contacting WIH and signing a new or modified agreement or an amendment to this Agreement, specifying their decisions.

Patient and Partner further understand that certain uses or dispositions of embryos may also require approval by WIH. WIH is not obligated to proceed with any attempted transfer to the Patient of any embryos if the IVF Program determines that the risks associated with doing so may outweigh the potential benefits. WIH also retains the right to terminate this Agreement upon written notice for other reasons that it considers appropriate. In any circumstances of termination of this Agreement where embryos that have been cryopreserved remain in storage, Patient and Partner will be contacted and all reasonable efforts will be made to arrange for disposition of such embryos in accordance with Patient's and Partner's desires at such time.

PATIENT AND PARTNER HEREBY MAKE THE FOLLOWING DECISION REGARDING THE FINAL DISPOSITION OF FROZEN EMBRYOS THAT ARE STORED IN ACCORDANCE WITH THIS AGREEMENT AND NOT USED FOR A LATER PREGNANCY:

At the time of Patient's 55th Birthday, WIH is directed to dispose of the embryos as indicated below:

(Choose **one** by initialing the corresponding spaces.)

A. _____ _____
Patient's Initials Partner's Initials (if applicable)

A. **Transport:** I/We will arrange for transport of remaining embryos to another facility for storage or possible donation to another person.

B. _____ _____
Patient's Initials Partner's Initials (if applicable)

B. **Discard:** Embryos are thawed and discarded.

In the event of any of the following special circumstances, WIH is directed to dispose of the embryos as indicated below:

(i) DEATH OF THE **PATIENT**:

(Choose **one** by initialing the corresponding spaces.)

A. _____ _____
Patient's Initials Partner's Initials (if applicable)

A. Partner will assume ownership and control if able and willing; otherwise, the embryos will be thawed and discarded.

or

B. _____ _____
Patient's Initials Partner's Initials (if applicable)

B. Embryos are thawed and discarded.

(ii) DEATH OF THE **PARTNER**:

(Choose **one** by initialing the corresponding spaces.)

A. _____ _____
Patient's Initials Partner's Initials

A. Patient will assume ownership and control if able and willing; otherwise, the embryos will be thawed and discarded.

or

B. _____ _____
Patient's Initials Partner's Initials

B. Embryos are thawed and discarded.

(iii) DEATH OF **PATIENT** AND **PARTNER**

In the event of the death of the Patient and Partner, WIH is directed to thaw and discard the embryos. _____ _____
Patient's Initials Partner's Initials

5. **General Acknowledgment by Patient and Partner**

Patient and Partner acknowledge that they have read this entire document and have been given the opportunity to ask questions of WIH regarding this Agreement, which have been answered to their satisfaction, and consult with any attorney and/or other advisor(s) of their choice regarding this Agreement. Patient and Partner acknowledge that this Agreement contains the entire agreement between and among the parties regarding the continued storage of cryopreserved embryos and supersedes any and all prior agreements, understandings, representations, and discussions, whether written or oral, between the parties. Patient and Partner further acknowledge that they understand that they can change any of the decisions reflected in this Agreement before action has been taken in reliance on such decisions by contacting WIH and signing a new or modified agreement or an amendment to this Agreement.

FOR INPATIENTS: AFFIX PATIENT LABEL **OR**
WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

The signing of this Agreement by the **Patient** MUST be witnessed by a member of the Women and Infants Fertility Center (WIFC) clinical staff. The signing of this Agreement by the **Partner** (if applicable) may be witnessed by a member of the WIFC staff or signed in front of a duly licensed Notary.

_____
Signature of Patient

_____
Signature of Partner (*if applicable*)

_____
Date

_____
Date

_____
Date of Birth

_____
Date of Birth

_____
Witness Signature

_____
Witness Signature

_____
Signature of WIH Representative

_____
Print Name

_____
Date

_____
Witness Signature

State of _____
County of_____

On this_____day of_____, 20___, before me, the undersigned notary public, personally appeared_____, personally known to the notary or proved to the notary through satisfactory evidence of identification to be the person whose name is signed on the preceding or attached document, and acknowledged to the notary that he or she signed it voluntarily for its stated purpose.

_____

40735

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

PATIENT CONSENT FOR FERTILITY TREATMENT DURING COVID-19 AT WOMEN & INFANTS FERTILITY CENTER

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

C19-40735 (5-2020)

COVID-19 has been declared a worldwide pandemic by the World Health Organization. Although the exact mode of transmission is not entirely known, COVID-19 is contagious and is believed to spread by person-to-person contact. Despite taking reasonable preventative measures that are aimed to prevent the spread of COVID-19, an inherent risk of becoming infected with COVID-19 by virtue of proceeding with fertility treatment still exists.

By seeking treatment at Women & Infants Fertility Center I _____
(Patient's Name)

(or _____ for _____)
(Legal Guardian) (Patient's Name)

and _____ (if applicable) acknowledge and understand:
Partner's Name

1. Despite all precautions offered to me/us or taken by my/our providers, there is no guarantee that I/we will not be exposed to and/or infected with COVID-19.
2. Use of personal protective equipment (PPE) can minimize risk but does not eliminate the risk of transmission of COVID-19.
3. Possible exposure to COVID-19 may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and/or the risk of death.
4. The impact of COVID-19 on pregnancy for both the mother and baby is not fully known. I/we acknowledge that any febrile illness in early pregnancy may increase the risk of miscarriages and birth defects and that pregnant women appear to be at greater risk of severe complications from other respiratory viral infections such as influenza.
5. Even if I/we have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus, there is a chance I/we may have contracted COVID-19 after the test and I/we acknowledge that I/we may still transmit the undetected virus to another person.
6. My/Ourtreatment/procedure may be delayed or canceled should I/we develop symptoms, be tested positive for COVID-19 or for a variety of others reasons including changing regulations and restrictions surrounding COVID-19, availability of staff, the availability of adequate PPE or other reasons. If treatment is modified or canceled this can interfere with the ability to become pregnant through treatment as well as have financial consequences including not being reimbursed for expenses already incurred.
7. I/we are expected to follow reasonable precautions set forth by the WIFC such as wearing a facemask at all times in the clinic and to observe social distancing and proper handwashing both inside and outside of the clinic during the course of treatment.
8. These precautions may also include the request to self-quarantine and to pursue any testing for patient, or partner if applicable, related to COVID-19 before treatment. I/we understand that it may be necessary to obtain this testing at an outside lab and there may be extra costs associated with this testing.
9. Failure to comply with these requests, follow recommended precautions, as well as exposure to, developing symptoms of, or testing positive for COVID 19 may result in the delay or cancelation of treatment.
10. If treatment is delayed or canceled, this can have financial consequences including not being reimbursed for expenses already incurred.

11. The staff at WIFC is providing fertility treatment and I/we are responsible for obtaining other healthcare needs through other providers including routine gynecologic and primary care, any ongoing obstetric care, and any care related to COVID-19.
12. I/we have the option to postpone fertility treatment to minimize the risk of acquiring COVID-19.

I/we have been counseled about resources available to provide further information about COVID-19. I /we have had the opportunity to read this form, or have it read to me/us, and I/we understand it. I/we have had the opportunity to ask questions and they have been answered to my/our satisfaction. Understanding all of the above, I/we desire to proceed with fertility treatments.

Time: _____ AM / PM Date: _____ Signature: _____
(Patient or Legal Guardian)

Relationship: _____

Time: _____ AM / PM Date: _____ Signature: _____
Partner, if applicable

Provider's Acknowledgement:

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Provider)

Print Name: _____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Interpreter)

Print Name: _____
(Interpreter)

For Partner's Signature if not signed at WIFC

STATE OF _____

COUNTY OF _____

Then personally appeared before me the above named _____, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of _____, 20____.

NOTARY PUBLIC: _____
MY COMMISSION EXPIRES: _____