Consent for In Vitro Fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), and Embryo Cryopreservation/Disposition

Patient Name (please print)

Patient DOB (MM/DD/YYYY) **Patient eIVF number**

Partner Name (if applicable, please print)

Partner DOB (MM/DD/YYYY) **Partner eIVF number**

Please read the following consent carefully.

If you do not understand the information provided, please speak with your physician or nurse. After reading this consent and signing, you agree to the elements of IVF treatment in your upcoming IVF treatment cycle.

This consent must be signed by both Patient and Partner (if applicable).

Treatment cannot be started until all consents are signed.

Oocyte (Egg) Development and Monitoring:

Stimulation of ovaries to induce maturation of multiple follicles with injectable medications. (**Please see section on Medications in the IVF Treatment Guide**). Serial ultrasound examinations and blood tests to monitor growth and development of follicles and female hormone status.

Transvaginal Oocyte (Egg) Retrieval:

Retrieval of eggs through ultrasound-guided aspiration is performed under IV sedation or other forms of anesthesia. A special needle is used to pass through the vaginal wall in order to enter the ovarian follicles.

Insemination of Oocytes (Eggs):

Unless otherwise specified, I/we agree to inseminate **ALL** viable oocytes. If I/we do not wish to inseminate all viable oocytes, I/we understand that it is my/our responsibility to provide my/our physician with specific instructions to either discard the remaining oocytes not inseminated **OR** cryopreserve the remaining oocytes not inseminated (a separate **Consent for Oocyte Cryopreservation, Storage and Disposition** is required). **I/we understand that there may be additional cost to me/us if I/we choose to cryopreserve oocytes not inseminated.**

Regular vs Intracytoplasmic Sperm Injection (ICSI) Insemination:

I/We have discussed with my/our physician the different options of insemination (regular vs ICSI) and the indications for ICSI have been discussed with me/us by my/our physician. I/we agree to the method of insemination that is appropriate for my/our specific clinical situation, as recommended by my/our physician.

In most circumstances, the medical indications for the use of ICSI are anticipated based on pre-cycle semen parameters. However, at times, based on the embryology laboratory assessment of the sperm on the day of the oocyte retrieval, the unanticipated use of ICSI may be warranted. If this unanticipated situation occurs, I/we agree to ICSI, if indicated. There may also be occasions when, unexpectedly, no fertilization (or a very low fertilization rate) is observed the day after oocyte retrieval. If this unanticipated situation occurs, I/we agree to "rescue" ICSI, if indicated.

I/We understand that, depending on our health insurance plan, there may be additional costs to me/us, if ICSI is performed for unanticipated reasons.

I/We understand that if we do NOT consent to ICSI under ANY circumstances, it is my/our responsibility to notify my/our physician of this decision.

Embryo Transfer:

Placement of developing embryo(s) into the uterus by means of a catheter (small tube) inserted through the cervix. I/we have had discussion with my/our physician regarding the appropriate number of embryos to be transferred consistent with current Society for Assisted Reproductive Technology (SART)/American Society for Reproductive Medicine (ASRM) guidelines and professional standards of care.

Embryo Cryopreservation of viable, high quality embryos (if any) not transferred:

I/We understand that to date, there are no known effects from long-term storage of cryopreserved (frozen) embryos. Although there are theoretical risks of congenital malformations, I/we understand that the best available research suggests that the rate of birth defects in children born following the cryopreservation of embryos is the same as the rate observed in an age-matched group of pregnant women who conceived without assisted reproduction:

CHOOSE ONE ANSWER PLEASE:

1. **_____ Patient initials _____Partner initials (if applicable) I/We AGREE to embryo cryopreservation**

OR

2. **_____Patient initials _____Partner initials (if applicable) I/We DO NOT AGREE to embryo cryopreservation**

Disposition of Cryopreserved Embryos:

Any disposition of embryos requires the written authorization of both partners. If your embryos were formed using eggs/sperm from a third party donor, your instructions to donate these embryos must be in accordance with prior agreements with the egg/sperm donor or applicable law. Your instructions to donate the embryos may require separate consent from the egg/sperm donor.

I/We understand and agree that in the event of death or incapacitation of one partner, the embryo(s) will become the sole and exclusive property of the surviving partner, unless otherwise directed by law, a court order or as designated in my/our will. If the surviving partner, friends or family members wish to conceive with these embryos after your death, a legal document indicating this intent will be required.

I/We understand that the cryopreserved embryos will incur a charge according to the Fees for Embryo Cryopreservation and Storage policy of Boston IVF. Cryopreserved embryos will be maintained until specific directives and authorization for those directives are provided by me/us. Options for disposition are discussed in the Consent for Treatment Guideline and consent forms are required at the time of disposition. Boston IVF reserves the right at its sole discretion to make decisions regarding the final disposition of cryopreserved embryos if fee obligations are not met. In the event of divorce or dissolution of the relationship between patient and partner, embryos cannot be used, donated or discarded without the expressed, written consent of both parties or as directed by a court order, even if donor eggs/sperm were used.

Donating Discarded Sperm, Unfertilized Eggs or Embryos:

When undergoing infertility testing and treatment, the laboratory at Boston IVF may have surplus sperm, unfertilized eggs or embryos which are not used for your treatment and ordinarily are discarded. The purpose of this consent is to inform you of the option to donate the otherwise discarded gametes or embryos to scientific research. Scientific research studies involving discarded sperm, unfertilized eggs or embryos are aimed at gaining a better understanding of infertility and seek to improve techniques used in the treatment of infertility. If discarded sperm, eggs or embryos are studied as part of a human research project it would only be done in compliance with an Institutional Review Board (IRB) approved protocol. No discarded materials would be used to establish a pregnancy. Donation of discarded materials is voluntary, and your decision will not affect your clinical care. You may change your mind at any time without penalty or loss of benefits to which you are otherwise entitled. By signing below, you are agreeing to donate or not to donate your discarded sperm, unfertilized eggs or embryos to research:

Choose one of the options below regarding your discarded sperm, unfertilized eggs or embryos

a. **I DO** ☐ **/ DO NOT** ☐ **agree** to donate sperm that will be discarded.

b. **I DO** ☐ **/ DO NOT** ☐ **agree** to donate unfertilized eggs that will be discarded.

c. **We DO** ☐ **/ DO NOT** ☐ **agree** to donate embryos that will be discarded

Financial Responsibility

Financial responsibility for all services and medical treatments provided by Boston IVF, the physicians and staff, laboratory services and hospital costs associated with medical care, are the sole responsibility of the individual and/or couple receiving these treatments. Clinical and financial staff will attempt to predict, as best they can, the cost of services before they are rendered, but the costs may vary depending on unforeseen circumstances, insurance company decisions, and/or complications of the treatment. Boston IVF reserves the right to change its charges and fees. Financial staff will work with the couple to determine possible insurance reimbursement for care rendered, but the ultimate responsibility for payment rests with the couple, not their insurance company.

Acknowledgment

I/We hereby acknowledge that I/we have received the IVF Treatment Guide and have been given ample opportunity to review it. I/We have read the IVF Treatment Guide in its entirety and reviewed the information in this consent form for In Vitro Fertilization (IVF), intracytoplasmic sperm injection (ICSI), and embryo cryopreservation and disposition. I/We have been fully advised of the purpose, risks and benefits of each of the procedures indicated, as well as assisted reproduction generally, and have been informed of the available alternatives and risks and benefits of such alternatives, including non-treatment and adoption. I/We have conferred with my/our physician and medical team, during which time we have discussed: the risks and benefits of ART treatment, and my/our individual medical circumstances. I/We have been provided with adequate opportunity by my physician and nursing team to address my/our questions about the treatment elements described in this consent and all my/our questions have been answered to my/our satisfaction. I/We have had ample time to reach my/our decision, free from pressure and coercion, and agree to proceed with my/our participation in Assisted Reproduction services as stated. **Unless treatment decisions change, this signed consent form will be considered valid for one year. If there are changes to these treatment decisions, a new consent form must be signed.**

Witness of Consent Form (if this form is completed no need to complete notarization form)

Patient Name (print) **Patient Signature** **Today's Date** (MM/DD/YYYY)

Date of Birth (MM/DD/YYYY)

PATIENT- TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:_____ State/Country:_____ Expiration Date:_____ (MM/DD/YYYY)

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

Partner Name (if applicable, print) **Partner Signature** **Today's Date** (MM/DD/YYYY)

Date of Birth (MM/DD/YYYY)

PARTNER - TYPE OF PICTURE IDENTIFICATION: ☐ Driver's License ☐ Passport ☐ Other: _____

ID NUMBER:_____ State/Country:_____ Expiration Date:_____ Date (MM/DD/YYYY)

Witness Name and Title (print) **Witness Signature** **Today's Date** (MM/DD/YYYY)

Physician Attestation

The above mentioned patient and partner (if applicable) have been informed and counseled by me and other team members regarding the risks and benefits of the relevant treatment options, including non-treatment. The patient and partner (if applicable) expressed understanding of the information presented during the discussion.

Physician Name (print) **Physician signature**

Today's Date (MM/DD/YYYY)