CONSENT FORM FOR
PARTNER ASSISTED REPRODUCTION (PAR)
Intracytoplasmic Sperm Injection (ICSI), and Embryo Cryopreservation/Disposition

Patient Name (please print)

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

Partner Name (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 PAR IVF treatment in your upcoming treatment cycle.

Patient and Partner must present PHOTO IDENTIFICATION and sign in the presence of an authorized Boston IVF staff member or authorized delegate.

This consent must be signed by both Patient and Partner.
If you and/or your partner are unable to sign the consent in the presence of an authorized Boston IVF staff member or authorized delegate, the consent must be notarized using the Notarization Form attached to this consent and returned to your physician team.

Treatment cannot be started until all consents are signed.

Partner Assisted Reproduction (PAR) is a fertility treatment that helps a patient achieve a pregnancy. PAR is a treatment whereby one partner has their eggs removed and fertilized by donor sperm in the laboratory. The fertilized eggs (embryos) are then transferred into their partner's uterus. Extra embryos can be frozen for future use. This treatment can be performed for medical or non-medical reasons.

This consent explains PAR and describes the major risks. In addition, the responsibilities of those who participate in this treatment are discussed. This consent is valid for a period of one calendar year after it has been signed. Please make a copy for your records. It is recommended that you review the consent prior to each treatment cycle. If you have any questions about your treatment it is your responsibility to speak with your physician.

Although both partners are considered patients under the care of Boston IVF Physicians throughout the PAR consent the parties will be referred to as:

Patient: the partner having their eggs retrieved
Partner: the partner having the embryo/s transferred into their uterus.

PAR cycles differ from donor oocyte cycles in that the patient and partner are sexually intimate, both patient and partner intend to co-parent any offspring and they co-own any embryos created.

Oocyte (Egg) Development and Monitoring:

Stimulation of ovaries to induce maturation of multiple follicles with injectable medications. (**Please see section on Medications for IVF Treatment in the Consent for Treatment book**). Serial vaginal ultrasound examinations and blood tests to monitor growth and development of follicles and 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, we agree to inseminate **ALL** viable oocytes. If we do not wish to inseminate all viable oocytes, we understand that it is our responsibility to provide 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). **We understand that there may be additional cost to us if we choose to cryopreserve oocytes not inseminated.**

Regular vs Intracytoplasmic Sperm Injection (ICSI) Insemination:

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

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

We understand that if we do NOT consent to ICSI under ANY circumstances, it is our responsibility to notify 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. We have had discussion with 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:

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, 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 pregnant population who conceived without assisted reproduction:

CHOOSE ONE ANSWER PLEASE:

1. _____ **Patient initials** _____**Partner initials** **We <u>AGREE</u> to embryo cryopreservation**

OR

2. _____**Patient initials** _____**Partner initials** **We <u>DO NOT AGREE</u> to embryo cryopreservation**

Disposition of Cryopreserved Embryos:

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

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 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.

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 Donor Sperm, Unfertilized Eggs or Embryos:

When undergoing infertility testing and treatment, the laboratory at Boston IVF may have surplus donor 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 donor 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 donor 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 donor sperm, unfertilized eggs or embryos to research:

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

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

b. **We 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

We hereby acknowledge that we have received the Consent for Treatment book and have been given ample opportunity to review it. We have read the Consent for Treatment book in its entirety and reviewed the information in this consent form for PAR In Vitro Fertilization (IVF), intracytoplasmic sperm injection (ICSI), and embryo cryopreservation and disposition. 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. We have conferred with our physician and medical team, during which time we have discussed: the risks and benefits of ART treatment, and my/our individual medical circumstances. We have been provided with adequate opportunity by our physician and nursing team to address our questions about the treatment elements described in this consent and all my/our questions have been answered to our satisfaction. We have had ample time to reach our decision, free from pressure and coercion, and agree to proceed with our participation in Partner 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 _____/_____/_____
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)

Notarization Form **(This form is only needed if not able to have witnessed at Boston IVF)**

Patient Name (print) **Patient Signature** **Date of Birth** (MM/DD/YYYY)

State of:_____ County of: _____

On this _____ day of _____ 20____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the proceeding or attached document in my presence.

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

_____/_____/_____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title
My appointment expires: _____/_____/_____ (MM/DD/YYYY)

Partner Name (if applicable, print) **Partner Signature** **Date of Birth (MM/DD/YYYY)**

State of:_____ County of: _____

On this _____ day of _____ 20____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the proceeding or attached document in my presence.

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

_____/_____/_____
Today's Date (MM/DD/YYYY)

_____
Notary Signature

_____
Title
My appointment expires: _____/_____/_____ (MM/DD/YYYY)