BOSTONIVF

COVID-19 CONSENT

This Acknowledgement of risks regarding COVID-19 (this "***Acknowledgement***") applies to all physicians, nurses, embryologists and other practitioners, physician practices, fertility laboratories, tissue storage repositories and management services organizations owned, directly or indirectly, managed by, or otherwise affiliated with, Boston IVF (each, a "***Provider***"). Both the patient and the patient's partner, as applicable, are parties to this Agreement and are referred to as "I". This Acknowledgement lays out the legal terms and conditions that apply to all treatment(s), procedure(s) or service(s) (referred to in this document as "***Services***") I will receive from any Provider.

Acknowledgement Regarding Precautions During Coronavirus (COVID-19)

Recommendations for fertility treatments and services laid out by professional organizations and regional and local Departments of Health are aimed at safeguarding the health and safety of patients and providers. The Provider has determined it is appropriate to deliver care related to specific infertility treatments and will utilize available means to manage the risk of disease transmission between persons.

I understand that information regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that risk(s) may come to light of which we are presently not aware. I acknowledge that guidance from the Center for Disease Control ("***CDC"***), the American Society for Reproductive Medicine ("***ASRM"-*** the fertility providers' professional association) and the World Health Organization ("***WHO"***) may change at any time based on new information regarding COVD-19.

I further understand that the CDC and ASRM and the American College of Obstetrics and gynecology ("***ACOG***") have not determined what risks, known or unknown or if any, the virus that causes COVID-19 might have on patients undergoing infertility treatment or patients who become pregnant.

I understand that there may be risks associated with contracting COVD-19 during pregnancy. Although there is no current evidence of maternal-fetal transmission of COVID-19, data is limited; however, prior data with other illness support that a febrile illness of any kind in pregnancy may pose risks including miscarriage, stillbirth, and preterm birth. Further, the impact of the medications used to treat COVID-19 have not been studied in pregnancy.

For patients undergoing oocyte retrieval, I understand that if, during the course of ovarian stimulation leading to my oocyte retrieval, I test positive for COVID-19, the cycle will be cancelled. I understand that there are financial implications should this occur.

I understand, that I might have been or may become exposed to COVID-19 prior to or while receiving Services by Provider. I understand that despite the measures that Provider is taking I may become exposed to COVID-19 during my/our treatment with Provider or on account of such treatment. I understand that, at the present moment, the availability of testing is limited and the Provider has limited ability to refer patients for COVID-19 testing. I understand that I may have the option to be tested for COVID 19 before my cycle. If I choose to be tested, I understand and agree that I must discuss these results with the Provider prior to any treatment. I understand that COVID-19 tests are not 100% accurate. I understand that PCR tests have

varying levels of false negatives, and positive antibody tests may not result in immunity from COVID. If I demonstrate symptoms, my provider may cancel my cycle even if I have been tested.

I further understand that should I be directly exposed to COVID-19, be diagnosed with COVID-19, or become symptomatic with any illness which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), Provider may elect to postpone, reschedule, or terminate or modify the manner in which Provider renders Services, depending on the clinical circumstances. I understand that it is my obligation to inform the clinic if I am not feeling well, have a fever or any other symptoms associated with COVID-19, or if I have reason to believe that I have been exposed to COVID-19. I understand that should any of the forgoing apply to me, the clinic may elect to reschedule my appointment, visit, or any Services a later date.

I agree that I will contact the Provider to reschedule my appointment if I experience any of the following symptoms: cough, fever, shortness of breath, sore throat, loss of smell or muscle aches. I also agree that I will inform the Provider immediately if I have been in close contact with an individual known to have COVID-19, or I have had exposure to an individual with the previously listed symptoms.

I further understand that there may come a point where the Provider may not be able to support continued Services (e.g, illness of doctors or laboratory staff, which would prevent Provider from rendering services or clinic being required to pause operations) and if this occurs the Services may be postponed or cancelled.

I understand that prior to and during my treatment that I should continue to practice preventive measures, i.e. physical distancing, handwashing, use of personal protective equipment (PPE- i.e. masks and gloves, hand sanitizer) and all current CDC recommendations to reduce the risks of infection.

I understand that the Provider may be under a Stay at Home or Shelter in Place Ordinance that may restrict my ability to travel in my local community. I agree that I will familiarize myself with all such applicable orders. I acknowledge that I am leaving my home for medical treatment and that I should and will take precautions to remain isolated during my travel to not increase the chance of infection to myself or others. I agree to wear a mask, either fabric or medical, for the duration of my commute to the Provider's office, and to sanitize my hands upon arriving at the Provider.

I understand that the Provider is taking extra precautions to limit the chance of spreading COVID-19, including prescreening for fever and social distancing practices during my treatment. I agree to comply with these efforts, and I understand that my failure to do so may result in the cancellation of my appointment. I understand that if during my prescreening at the clinic I am found to have a fever, I will be asked to reschedule my appointment at such a time when the Provider believe it is appropriate. I acknowledge that despite these efforts it is still possible that I could become infected with COVID-19 during my travel to and from the clinic or while at the clinic. I agree to hold the clinic, physicians, and staff harmless in the event that I am infected.

BOSTONIVF

COVID-19 CONSENT

The risks, potential benefits of and alternatives to this treatment or procedure have been explained to me by the Provider. I understand the explanation that has been given to me.

I have had the opportunity to ask any questions I may have about the Services and this Acknowledgement and those questions have been answered to my satisfaction.

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)