BOSTON IVF

120 Day Consent to Thaw and Transfer Cryopreserved Embryo

This consent is valid for 120 days from the date signed

____
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**

Treatment cannot be started until all consents are signed by Patient and Partner (if applicable).

Patient must present PHOTO IDENTIFICATION at the time of the embryo transfer.

Please initial each of the following items as an acknowledgement of your understanding of each statement and consent to the indicated elements of treatment when applicable.

Patient Initial	Partner Initial	
______	______	**CHANGE IN MARITAL STATUS** If prior to the expiration of this Consent, there is a change in our marital relationship including, but not limited to, separation, divorce or death, such event shall automatically constitute a revocation of this Consent. **We agree that it is our responsibility to notify Boston IVF of any such event.** Failure to notify will mean that we have an obligation to indemnify and hold Boston IVF harmless in the event that a claim is brought against Boston IVF alleging, among other things, that you performed a Frozen Embryo Transfer for which our consent was revoked because of a change in our marital status.
______	______	**INSTRUCTIONS FOR THAW AND EMBRYO TRANSFER** I/We understand that not every embryo that is thawed is suitable for transfer. Accordingly, more embryos than the number actually transferred may need to be thawed in order to obtain the number of embryos which I/we have requested to be transferred. If excess embryos are thawed and not used, they will be re-cryopreserved should they meet criteria.
______	______	**RISKS OF PROCEDURES** I/we have been fully advised of the risks and benefits of transferring cryopreserved embryos as explained in the **IVF Treatment** Guide. I/we have conferred with my/our physician and medical team and discussed that there are risks associated with pregnancy and especially multiple pregnancy, should it occur, and that my/our obstetrician will provide my/our treatment during any such pregnancy. I/We understand that there is no guarantee of successful pregnancy following embryo transfer.

Copyright © 2023 by Boston IVF. All Rights Reserved

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 IVF Treatment Guide I 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.

Copyright © 2023 by Boston IVF. All Rights Reserved

BOSTON IVF

CONSENT FOR TREATMENT

I/We hereby acknowledge that I/we have been assigned and read the **IVF Treatment Guide** and understand the general information provided within it. I/We have reviewed the information in this consent with my/our physician and have been provided with adequate opportunity by my/our physician and nursing team to address my/our questions about the thaw and transfer of my/our cryopreserved embryos. I/We have conferred with my/our physician and medical team, during which time I/we have discussed (1) the risks and benefits of treatment with assisted reproduction technologies, (2) my/our individual medical circumstances and (3) options including non-treatment and/or adoption, and any questions I/we had were answered.

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)

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)

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)

Copyright © 2023 by Boston IVF. All Rights Reserved

BOSTON IVF

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

______________________	______________________	______________________
Patient Name (print)	**Patient Signature**	**Today's Date (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**	**Today's Date (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)

Copyright © 2023 by Boston IVF. All Rights Reserved