Piedmont Reproductive Endocrinology Group (PREG)
Application for Recipient of Anonymous Embryo Donation

Piedmont Reproductive Endocrinology Group (PREG)
17 Caledon Court, Suite C
Greenville, SC 29615
Telephone: 864-232-7734
Fax: 864-232-7099
www.pregonline.com

APPLICANT **SPOUSE**

Name: _____ Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ E-Mail: _____

Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Date of Birth: _____

Place of Birth: _____ Place of Birth: _____

Age: ____ Social Security #: _____ Age: ____ Social Security #: _____

Date of Marriage: _____ Number of Years Infertile: _____

Smoker: ____ yes _____ no Smoker: _____ yes _____ no

Name/Age/Sex of Children in the home and biological relationship(s): _____

_____

_____

Applicant **Spouse**

Dates of Marriage(s) Dates of Divorce(s) Dates of Marriage(s) Dates of Divorce(s)

_____ _____ _____ _____

Applicant's Spouse's

Employment: _____ Employment: _____

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ADDITIONAL INFORMATION
(How Quickly Do You Want to go Through the Process?)

As Quickly As Possible _____ Just Getting Started _____
Within a Year _____ Other _____

PREG APPLICATION POLICY REQUIRES YOU TO INCLUDE THE *nonrefundable* APPLICATION FEE OF $500 ALONG WITH YOUR APPLICATION. CHECKS CAN BE MADE OUT TO PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP.

PREG Use: Date Application Received: _____ Accepted: Yes ____ No _____

(If No – why?): _____

Date Placed on Waiting List: _____ Date Follow up Packet sent: _____

Date Follow Up Information Completed: _____ Date Matched: _____

FILE IN RECIPIENT'S CHART ONLY

Piedmont Reproductive Endocrinology Group
17 Caledon Court, Suite C
Greenville, SC 29615

For Recipients' Records

PREG Embryo Donation Selection Form

Embryo Donor #: *Date of Profile:*

I have had the opportunity to review various embryo donor profiles and have chosen this profile as the one that I would like to use for my frozen embryo transfer. My questions regarding the donor profile have been answered to my satisfaction. I am ready to accept these for use in my embryo donation recipient cycle.

Accept Donor _____ **YES** _____**NO**

Anticipated cycle date of DER cycle: _____

_____ **Date:** _____
Recipient Name (Print and sign)

For Office Use Only:
Embryo Donor # _____ was selected.
Signed Profile accepted with $ _____ deposit collected on_____
by _____. Donor will be reserved for above proposed cycle date.
Additional Notes:
_____
_____

Piedmont Reproductive Endocrinology Group (PREG), PA

Embryo Donation Frozen Embryo Transfer Fee Schedule
Effective 03/2012 (Charges are subject to change without notice)

Patient Name:_____ **Date:**_____

Application Fee:
(Required payment with initial application to be placed on the waiting list) **$ 500.00**

Deposit required when embryos are accepted: **$ 1,500.00**

Embryo Donation Cycle Fee:
Includes all monitoring: ultrasounds, bloodwork (Estradiol, Progesterone, LH), office visits, Physicians charges, laboratory fees (thawing, culture,) embryo transfer with ultrasound guidance, supplies.

Pre-pay Total: $ 7,800.00

Possible Additional Charges NOT included in pre-pay:

First Day Freezing & First year storage of embryos	$ 1,000.00
Bladder Catheter used during embryo transfer	$ 100.00
Embryo thawing after first straw	$ 300.00 per straw

Additional Charges NOT included in pre-pay:

Medications (ALL) *medication costs will be paid directly to the pharmacy*	Estimate: $ 1,000.00
Embryo Storage after the first year	600.00 (per year)

•Any of the following initial or screening tests (but not limited to): endocrine labs, STD labs, Prenatal Profile, OAR or AMH labs, baseline ultrasounds, medical and physical examinations, HSG, sonohystogram, semen analysis, other sperm function tests etc. or other recommended testing performed to ensure couples are candidates for treatment are not covered in any of PREG Self-Pay Fee pricing.

• Pre-pay for the application fee is due in full on the day the recipient's name is added to the waiting list. And the balance of the fees will be due at Embryo Donation orientation **no exceptions**. We accept all forms of payment. Per PREG financial policy we can not accept any post-dated checks.

• **Please note that the prepay only covers the procedures listed above on page 1. The prepay will terminate the day after the initial pregnancy test. The pre-pay to PREG does NOT cover the cost of medications.**

• PREG does offer Spring Stone Patient Financing, My Medical Loans or Medical Financing as options for financing your procedure. For more information visit Pregonline.com for a link to those companies. ***Please be aware that the loan process does take 2-3 weeks to complete. Once the approval form has been received by PREG – it will be sent back the same day to process the payment to PREG. Neither finance company that PREG offers will finance the cost of medications.***

• All STD labs, Pre-Natal Profile Labs, OAR or AMH labs, additional testing, procedures, and / or office visits are ***not*** considered part of the Embryo Adoption pre-pay.

• Quest Diagnostic will also bill your insurance for phlebotomy fees that occur when labwork is drawn at PREG. This is a separate fee that is NOT included in the prepay. You will receive invoices from Quest for any remaining balance (if any).

• Your medications will be ordered on the day of your orientation. Once the pharmacy receives the order they will contact you for payment within 24 to 48 hours.

• If a refund is due after your cycle is completed or cancelled, please be aware it will be 8 to 10 weeks before a refund will be issued. However if there is any kind of balance on your account PREG will use the refund (if any) to pay off any balance(s). Also if using SpringStone or Medical Financing as payment for the cycle, there are fees paid by PREG to receive these loan amounts. The fees will be deducted from the refund amount (if any).

• If your cycle should get cancelled you will be charged for the services that were preformed up to the time of cancellation. Once you start a new cycle you are required to pre-pay the amount used from the original pre-pay on the previous cycle.

I have read and understand the cost and information given on this form.

_____ _____

Patient Signature Date

_____ _____

Financial Counselor/Witness Signature Date

Piedmont Reproductive Endocrinology Group (PREG)
INFORMED CONSENT FOR RECEIPT OF ANONYMOUSLY DONATED EMBRYOS/ WAIVER OF LIABILITY

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We, _____ ("Husband") and _____ ("Wife/Recipient") do hereby consent to receive anonymously donated embryo(s) under the care of our physician for the purpose of establishment of a pregnancy. This agreement sets forth the terms and conditions for such an embryo donation and we are the anonymous recipients ("Recipient") of the donated embryos. PREG only performs anonymous embryo donations for our patients using embryos originally created for use by other PREG patients.

We understand that the purpose of receiving anonymously donated embryos is to assist us in achieving a pregnancy. We realize that by requesting that our physician consider us for the receipt of donated embryos, we represent that we have been unable to conceive either naturally or with other assisted reproductive technologies. We further understand that it will be necessary for Wife to follow specific guidelines including but not limited to the taking of various hormonal preparations in order to prepare the uterus for receipt of the donated embryos. We are aware that embryos will only be transferred into the uterus.

We understand that ALL of the cryopreserved embryos that genetic/donating couple has remaining will be released to us in the relinquishment, which could be as few as one or two or more than ten embryos. We understand that we may only have enough embryos for one frozen embryo transfer or may have multiple frozen embryo transfer cycles depending on the number of embryos cryopreserved and how many survive thawing. We understand that we will have one year in which to thaw and perform as many embryo transfers as needed to conceive or until no further embryos are remaining. We understand that there will be an additional fee for each subsequent frozen embryo transfer cycle using the original donated embryos. If we have transferred all of the donated embryos from the original genetic/donating couple and have not had a live birth, then we may pursue another embryo donation using a different genetic/donating couple. The PREG fees that applied to the first donation will apply to subsequent matching of anonymous embryo donations. We agree to release any and all remaining embryos back to PREG for further matching to other couples who desire anonymous embryo donation once we have completed our attempts for conception(s) with the embryos. We understand that it is permissible to keep the rights to the remaining embryos in order to continue to conceive using the embryos after we have delivered our first child(ren) and will make every attempt to pursue additional FET cycles within one year after our first delivery. We agree to pay the annual storage fees for embryo cryopreservation while we are attempting conception with said embryos.

We realize that no specific genetic screening has been performed on the couple donating the embryos, and that there is at least a 3% risk of major birth defects including chromosomal or other genetic problems.

We agree to comply with all medical instructions and guidelines as directed by our physician and realize that our failure to do so may make us ineligible to receive embryo donation. We understand that in order to achieve the highest chance of pregnancy using donated embryos, it will be necessary for Wife to take a series of medications including injections, pills, estrogen patches and/or vaginal suppositories. We further understand that Wife will need to be monitored with tests of blood hormone levels and vaginal ultrasound exams.

We also recognize that if monitoring reveals an inadequate response of Wife to her own or administered hormones during the cycle that the transfer of embryos may be cancelled. **INITIALS** _____/_____

Piedmont Reproductive Endocrinology Group (PREG)
INFORMED CONSENT FOR RECEIPT OF ANONYMOUSLY DONATED EMBRYOS/ WAIVER OF LIABILITY

At the appropriate time as designated by our physician, the embryos will be transferred into Wife's uterus. This may require additional consent.

We understand that the purpose of this procedure is to create a pregnancy in Wife, but that there is no guarantee that embryo transfer will result in a pregnancy. In addition, it is possible that embryo transfer may not occur as a result of death of the embryos during transport or thawing. We understand that complications may arise either as a result of the embryo transfer or as a result of the pregnancy. Although such complications are uncommon and generally not serious, it is possible that serious complications up to and including permanent sterility or death of Wife could occur. In addition, we recognize that if a pregnancy does occur, a normal pregnancy cannot be guaranteed. Major birth defects, although not apparently increased by embryo cryopreservation or donation, occur with a frequency of approximately 3%. Abnormal pregnancies could also result in miscarriage, ectopic pregnancy, inherited diseases, or other problems. We further acknowledge that although screening procedures are performed, the risk of acquiring an infection such as HIV, AIDS, Hepatitis, or sexually transmitted diseases from the transfer of the embryos cannot be eliminated. We understand that Piedmont Reproductive Endocrinology Group (PREG) may attempt to rescreen the donors for these conditions, but any such attempt may not be successful and will not eliminate the risk. We agree to be tested for HIV, hepatitis B and C, Syphilis and other labs prior to receiving donated embryos. We understand that we may be able to sign a waiver allowing transfer of donated embryos where the results of any screening or testing performed on the donors indicates the presence of a relevant communicable disease and/or risk factors for or clinical evidence of relevant communicable disease agents or diseases and accepts the small risk of possibly acquiring an infection.

We further acknowledge that there may be unknown psychological risks both to us and to our offspring in connection with the procedures contemplated herein, and we agree to assume those risks. We agree to hold harmless Piedmont Reproductive Endocrinology Group (PREG), our physicians, medical director, and the employees and agents of all such entities, and all contracting parties for any such problems should they occur. We understand that psychological counseling is available at our expense to assist us in making decisions concerning embryo adoption, and we will request this counseling, if interested.

PREG follows ASRM Guidelines for the number of embryos to be transferred in an effort to reduce the number of high order multiple gestation pregnancies. We understand that it is to be expected that not all embryos which are thawed as a result of an anticipated transfer will be viable after being thawed. PREG will try to thaw the minimum number of embryos required to obtain the number of embryos desired for transfer. We do agree to the implantation of all viable embryos which survive thawing.

ANONYMOUS EMBRYO DONATION:

We agree and consent not to seek the identity of the embryo donors. We understand that Piedmont Reproductive Endocrinology Group (PREG) will not provide us with this information.

Husband: _____ **Wife:** _____

We agree to take full and complete responsibility for any and all complications that may occur as a result of the transfer of donated embryo(s). We understand that the couple donating these embryos has relinquished any and all right, title and interests to the embryo(s) and any child or children that may result from the transfer of such embryo(s). Furthermore, we agree to release the couple donating the embryos from any and all responsibilities or liabilities for problems which might occur related to or as a result of our receipt of their donated embryos, including but not limited to the potential complications noted above. We also agree to take full responsibility for the care and upbringing of the child or children that are born as a result of our receipt of donated embryos. We release the embryo donors from any and all responsibility and liability for support, care or custody of any offspring born to us as a result of our use of their embryos.

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INFORMED CONSENT FOR RECEIPT OF ANONYMOUSLY DONATED EMBRYOS/ WAIVER OF LIABILITY

However, in vitro fertilization and use of donated cryostored embryos are new medical procedures, the legal implications of which have not been fully considered by the courts and legislatures. For these reasons, PREG cannot make guarantees or promised to either Recipient or Donor about the enforceability of parental rights. PREG strongly advises Recipient to obtain legal counsel with respect to parental rights and responsibilities regarding resulting offspring. By signing this agreement, Recipient agrees that Recipient has had ample opportunity to review this agreement with legal counsel of Recipient's choosing, and Recipient has ultimately and freely decided whether to procure such legal counsel.

I HAVE READ THE ABOVE AND DISCUSSED RECEIPT OF DONATED EMBRYOS WITH OUR PHYSICIAN. ALL OF OUR QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY AND WE AGREE TO RECEIVE DONATED EMBRYOS AS DIRECTED BY OUR PHYSICIAN.
WE AGREE TO IRREVOCABLY WAIVE, RELEASE AND RELINQUISH ANY AND ALL RIGHTS, CLAIMS OR CAUSES OF ACTION OF ANY KIND, WHETHER KNOWN OR UNKNOWN AND WHETHER NOW EXISTING OR OCCURRING IN THE FUTURE, OVER AND AGAINST PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG), OUR PHYSICIAN, THE MEDICAL DIRECTOR, AND ALL EMPLOYEES, OFFICERS, DIRECTORS, CONTRACTORS AND AGENTS OF SUCH PARTIES AND WE AGREE TO PROTECT, DEFEND, HOLD HARMLESS AND INDEMNIFY SUCH PARTIES FROM AND AGAINST ANY AND ALL EXPENSES, CLAIMS, ACTIONS, LIABILITIES, ATTORNEY'S FEES, DAMAGES, LOSSES, PENALTIES, FINES, AND INTEREST OF ANY KIND WHATSOEVER (INCLUDING WITHOUT LIMITING THE FOREGOING, DEATH OF OR INJURY TO WIFE OR EMBRYOS AND DAMAGE TO PROPERTY) ACTUALLY OR ALLEGEDLY RESULTING FROM OR CONNECTED WITH THE EMBRYOS, THE DONATION OF THE EMBRYOS, ANY PREGNANCY RESULTING FROM DONATION, THE CRYOSTORAGE OF THE EMBRYOS, PHYSICAL OR MENTAL ABNORMALITIES, EMOTIONAL OR CHARACTER ABNORMALITIES, OR ANY OTHER MATTERS RELATED TO OR CONTEMPLATED IN THIS AGREEMENT.

Signature of Male	Date	Witness
Signature of Female	Date	Witness

NOTARIZATION FORM

State of)

County of) ss.

On this ____ day of _____, in the year 20____, before me, _____

_____ personally appeared and was personally

known to me or proven to me on the basis of satisfactory evidence as the person(s) whose name is subscribed to this instrument (Notarization Form), and I acknowledge that he/she/they executed it. I declare under penalty of perjury that the person(s) whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
Signature of Notary Public

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
CONSENT FORM

FROZEN EMBRYO TRANSFER (FET)

I _____(Wife/Partner) and _____(Husband/Partner)
Understand that this consent gives the embryology team at Piedmont Reproductive Endocrinology Group permission to thaw some or all of our embryos that we currently have in storage. We understand that not all of our embryos may survive the cyropreservation and thawing process. As such, we understand that in certain cases the embryologist may need to thaw more embryos, to obtain the desired number of viable embryos, then which we would like to have transferred. We also understand that in certain cases none of our embryos may survive the freeze/thawing process.

We understand that it is the general policy of this program to transfer no more than 5 (five) thawed embryos, in order to minimize the risk of multiple gestation while maximizing the per cycle success rates of the procedure. We understand that any excess cryopreserved embryos will be maintained in storage for us and will continue to be our responsibility and will be managed as directed in our original cryopreservation consent.

We consent to having _____(number) embryos _____/_____(initials) transferred during our FET cycle. Note: Again, more embryos may have to be thawed to obtain desired number transferred.

We understand that, although there have been no observed detrimental effects in the children born from the cryopreservation procedure, there can be no guarantee as to the normalcy of any pregnancy that develops following the transfer of a cryopreserved embryo.

We give our full consent to participate in a frozen embryo transfer treatment cycle. We have also read all of the above, or it has been read to us. We have been given the opportunity to ask questions about this treatment procedure and all of our questions have been answered to our complete satisfaction. A copy of this consent form has been provided to us.

_____

NAME OF PATIENT (Please print and sign) DATE

_____

NAME OF SPOUSE OR PARTNER (Please print and sign) DATE

_____

NAME OF PERSON OBTAINING CONSENT (Please print and sign) DATE

_____

NAME OF PHYSICIAN (Please print and sign) DATE

Piedmont Reproductive Endocrinology Group (PREG)
Recipient Embryo Donation Frozen Embryo Transfer Checklist

Name: _____ Date: _____ Cycle #:_____

Female: DOB: _____ Age:_____ Ht. _____ Wt. _____ BMI _____

MRN:_____ Diagnosis Codes: 1_____ 2_____ 3_____

Needs	Approved(Y/N)		Completed Date/Initials
Female:			
☐	_____	Medical History & Physical Completed	_____
☐	_____	TSH & PRL (within 1 year)	_____
☐	_____	Prenatal Profile PNP/STD Labs (within 6 months)	_____
		Spectrum (HIV, HbSAg, Hep C Ab, RPR, ABO, Rh, Ab Screen, Rubella Ab IgG, CBC)	
☐	_____	GC/Chlamydia NAT Urine)	_____
☐	_____	Cytomegalovirus (CMV) Total antibody **(Only if Sperm Donor Tests Positive)**	_____
☐	_____	HSG (if tubal disease) } within	_____
☐	_____	Saline Sono/Sounding (if normal tubes) } 1 year	_____
☐	_____	H/S, L/S (if surgery)	_____
☐	_____	Psychological Counseling (requested / declined)	_____
☐	_____	Consent Receipt Donated Embryos/ Waiver Liability	_____

Protocol:

FET

Physician has reviewed checklist and intended donated embryo recipient is medically cleared / not cleared for FET start.

Signature_____ **Date**_____

John E. Nichols, MD **John F. Payne, MD**

Cycle Administrative:

_____ FET Flow sheet Reviewed and Completed _____

_____ Orientation Class _____

_____ Payment Received _____

_____ Consents Signed (check below if signed) _____

___Embryo Selection Form _____FET _____Receipt Donated Embryos/Waiver Liability

_____ Sperm Donor of Embryo(s) Summary of Records Completed _____

_____ Oocyte Donor of Embryo(s) Summary of Records Completed_____

_____ Waiver of Abnormal Donor Screening/Testing Completed (if required)_____

PREG Recipient Donor Embryo Screening Labs

Name_____ MRN #_____

Appt Date_____ Physician_____

Lab work Needed	Testing Lab	Supplies
Endocrine Labs		
☐TSH	PREG	1 SST
☐Prolactin	PREG	
☐Prenatal Profile (PNP)- HIV, HbSAg, Hep C Ab, RPR, ABO, Rh, Ab Screen, Rubella Ab IgG, CBC	Spectrum	2-3 SST, 2 Purple
☐Chlamydia, NAT **(order with PNP)**	Spectrum	Urine
☐Gonorrhea, NAT **(order with PNP)**	Spectrum	Urine
☐ Cytomegalovirus (CMV) Total antibody (IgG and IgM) with reflex CMV IgM **(Only if Sperm Donor Tests Positive)** PREG recommends using CMV negative sperm donor	Labcorp/Viromed Spectrum	1 SST
OPTIONAL SCREENING		
☐Varicella Zoster Antibody IgG (optional if no Chicken Pox Hx)	Spectrum	1 SST
☐Pap (optional)	Spectrum	
☐_____		