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: _________________

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

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

Applicant:
Have You ever Terminated your Parental Rights to a Biological or Adopted Child?
Yes____ No ____ (If "Yes" please Explain) ____________________________________
____
____

Spouse:
Have You ever Terminated your Parental Rights to a Biological or Adopted Child?
Yes ____ No _____ (If "Yes" please Explain) _________________________________
____
____

PREG APPLICATION POLICY REQUIRES YOU TO INCLUDE THE *nonrefundable* **APPLICATION FEE OF $250 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: _____________

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

Piedmont Reproductive Endocrinology Group (PREG)
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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 ______/______**

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.

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), PA

Embryo Donation Frozen Embryo Transfer Fee Schedule

Effective 01/2010 (Charges are subject to change without notice)

Patient Name:__________________________________ MRN:__________________________

Application Fee: (received with initial Application to be placed on the waiting list) **$250.00**

Cycle Management Fee: **$750.00**

Screening and Testing of Embryo Donors Fee: **$400.00**

Embryo Donation Cycle Fee: **$3,000.00**

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

PREG Facility Fees: **$500.00**

Additional Charges not included in pre-pay:

Assisted Hatching	$ 330.00
Freezing and storage of embryos	$1000.00
Medications (ALL)	$500 – 700.00

Pre-pay Total: $ 4,900.00

- 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 except Discover credit card. Per PREG financial policy we can not accept any post-dated checks.

- Please note that the pre-pay only covers the procedures listed above. The pre-pay will terminate the day after the initial pregnancy test.

- PREG does offer My Medical Loans or Medical Financing as options for financing your procedure. For more information visit Pregonline.com for a link to My Medical Loans or MedicalFinancing.com.

- 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.

- 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 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 Signature	Date

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

Name: ______________________________________ Date: ______________Cycle #:______

Female: DOB: __________ Age:_______ Ht. ________Wt. ________ BMI ___________

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 Transfer _____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)**	Labcorp/Viromed Spectrum	1 SST

PREG recommends using CMV negative sperm donor

OPTIONAL SCREENING

☐ Varicella Zoster Antibody IgG (optional if no Chicken Pox Hx)	Spectrum	1 SST
☐ Pap (optional)	Spectrum	
☐ _________________________________		