WOMEN & INFANTS HOSPITAL
Providence, RI 02905

AGREEMENT FOR CONTINUED STORAGE OF CRYOPRESERVED OOCYTES

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ______________________________

DOB OR MR #: ______________________________

I, ______________________________, (or ______________________________ for
(Patient's name) (Legal Guardian's Name)
__________________________________) having previously consented to the
(Patient's name)
cryopreservation (freezing) of ooctyes (eggs), now enter into this *Agreement for the Continued Storage of Cryopreserved Oocytes* ("Agreement") with Women & Infants Hospital of Rhode Island (WIH) pursuant to the terms detailed below.

TERMS

1. **Duration of Cryopreservation**

All oocytes that are cryopreserved pursuant to this Agreement may be frozen and stored with WIH until, at maximum, the date of the Patient's 55th birthday, ___/___/___.

2. **Financial Terms**

There is no charge for the first year of storage of the cryopreserved oocytes. At the end of the first year continued storage is subject to an annual storage fee. Insurance may not cover this cost and, if continued storage is desired, Patient is responsible for the storage fee. Payment is due within 60 days of billing. In the event of nonpayment, after reasonable notification of such nonpayment mailed via certified mail to the Patient's last known address, as provided to WIH by Patient, WIH reserves the right to discontinue storage and discard the oocytes.

If WIH ceases to exist, Patient will be sent written notice so that arrangements can be made to have the oocytes discarded or transported to another center for continued storage. If upon receipt of such notice Patient fails to make appropriate, timely arrangements for the discarding or transport of oocytes (i.e. within 6 months of receipt of such notice), WIH reserves the right to discontinue storage and discard the oocytes.

3. **Change of Address**

Patient is responsible to notify WIH promptly in writing of any change in 1) address, 2) telephone number, and to notify WIH in writing of any information that WIH should have in order to discharge its obligations under this Agreement. Patient understands that the oocytes will be considered to be abandoned if (i) Patient has not paid in accordance with the Financial Terms above, or (ii) the maximum storage period is approaching and, despite diligent efforts including certified mail, WIH is unable to contact Patient at the last known address. If Patient's oocytes are considered to be abandoned, WIH reserves the right to remove the oocytes from storage and discard them.

4. **Decision Relating to Disposition of Frozen Oocytes**

The parties agree that the frozen oocytes are subject to Patient's disposition, except as otherwise provided in this Agreement (for example, oocytes may be discarded by WIH as a result of nonpayment or failure to provide updated contact information). The parties further understand and agree that all decisions about the disposition of the frozen oocytes must be the Patient's

decision, except where such disposition may be affected by applicable laws or by any court with jurisdiction over them.

Patient may change any of these decisions at any time before action has been taken in reliance on such decisions, by contacting WIH and signing a new or modified agreement or an amendment to this Agreement.

Patient understands that certain uses or dispositions of oocytes may also require approval by WIH. WIH is not obligated to proceed with any attempted transfer to the Patient of any embryos (eggs fertilized by sperm) created using the oocytes if the IVF Program determines that the risks associated with doing so may outweigh the potential benefits. WIH also retains the right to terminate this Agreement upon written notice for other reasons that it considers appropriate. In any circumstances of termination of this Agreement where oocytes that have been cryopreserved remain in storage, Patient will be contacted and all reasonable efforts will be made to arrange for disposition of such oocytes in accordance with Patient's desires at such time.

PATIENT HEREBY MAKES THE FOLLOWING DECISIONS REGARDING THE <u>FINAL DISPOSITION</u> OF FROZEN OOCYTES THAT ARE STORED IN ACCORDANCE WITH THIS AGREEMENT AND NOT USED FOR A LATER PREGNANCY:

<u>At the time of Patient's 55th Birthday, WIH is directed to dispose of the oocytes as indicated below:</u>

(Choose **<u>one</u>** by initialing the corresponding spaces.)

A. __________
Patient's Initials

A. **Transport:** I will arrange for transport of remaining oocytes to another facility for storage or possible donation to another person.

B. __________
Patient's Initials

B. **Discard:** Oocytes are thawed and discarded.

<u>In the event of any of the following special circumstances, WIH is directed to dispose of the oocytes as indicated below</u>:

(i) <u>DEATH OF THE **PATIENT**</u>:

(Choose **<u>one</u>** by initialing the corresponding spaces.)

A. _________
Patient's Initials

A. Patient's Partner or Legal Representative will assume ownership and control if able and willing; otherwise, the oocytes will be thawed and discarded.

or

B. _________
Patient's Initials

B. Oocytes are thawed and discarded.

5. **General Acknowledgment by Patient**

I acknowledge that I have had the opportunity to read this entire document and have been given the opportunity to ask questions of WIH regarding this Agreement, which have been answered to my satisfaction, and consult with any attorney and/or other advisor(s) of my choice regarding this Agreement. I acknowledge that this Agreement contains the entire agreement between and among the parties regarding the continued storage of cryopreserved oocytes and supersedes any and all prior agreements, understandings, representations, and discussions, whether written or oral, between the parties. I further acknowledge that I understand that I can change any of the decisions reflected in this Agreement before action has been taken in reliance on such decisions by contacting WIH and signing a new or modified agreement or an amendment to this Agreement.

The signing of this Agreement MUST be witnessed by a member of the Women and Infants Fertility Center (WIFC) clinical staff.

____
Signature of Patient /Legal Guardian

____
Relationship

____
Date

____
Patient's Date of Birth

____
Witness Signature

WIH Representative: ____________________

Signature: ______________________________

Date: _________________________________

Witness Signature: ________________________