CONSENT FOR THE CRYOPRESERVATION OF HUMAN OOCYTES(S)

I, THE UNDERSIGNED, and being of legal age and desirous of participating, with the advice of my physician signing below, in GRAMERCY FERTILITY SERVICES' (GFS) Oocyte Cryopreservation Program, hereby acknowledge, understand, agree and consent to the following:

1. EXPLANATION OF OOCYTE CRYOPRESERVATION

Reasons. Cryopreservation of oocytes (egg freezing) is a medical term describing the laboratory procedure by which human oocyte(s) retrieved through follicular aspiration is/are frozen before these can be inseminated and fertilized and stored for later thaw and use (i.e., fertilization) by patients to establish pregnancy.

Cryopreservation Process. The freezing and storage of my egg(s) will be conducted on the day the oocytes are retrieved. Normally, the oocytes are in the Metaphase II stage of its development. The laboratory personnel will transfer the eggs to be frozen from the culture media into a special solution containing a cryoprotectant compound in a process called vitirification. The oocyte(s) will be cooled very rapidly from room temperature to -150°C in a special cryostraw that will hold the oocyte(s). The oocyte(s) will then be transferred into the storage tanks containing liquid nitrogen for storage. If in the future these are thawed, any oocyte(s) which is/are determined to have not survived the thawing process will be discarded.

2. RISKS OF OOCYTE CRYOPRESERVATION

No pregnancy may occur. I understand that only a minority of patients may become pregnant after transfer of embryos resulting from thawed oocytes. Presently, there is no available reliable data on pregnancy rates from use of frozen oocytes in assisted reproductive technologies (ART).

Risks of Birth Defects. I understand that few laboratories worldwide have demonstrated the ability to freeze and preserve human oocytes and some have established pregnancies after transfer of the resulting embryos (from thawed oocytes) into patient's uterus. I understand that studies of frozen/thawed human oocytes and extensive investigations of cryopreserved animal pre-embryos have not demonstrated a significant increase in risk of abnormalities in offspring derived from these frozen/thawed oocytes. I understand that this does not mean that this freezing/thawing procedure will not eliminate the normal risk of fetal abnormalities or the obstetric complications incidental to pregnancy and delivery. However, the cryopreservation of human oocytes and the resulting embryo(s) does not appear to create an increased risk to the mother or to the fetus, although the possibility of a presently unforeseen risk cannot be completely eliminated.

Risks of Technical Procedures. The process of oocyte cryopreservation however is in itself a very risky procedure for the oocyte. The embryos are subjected to chemicals and to temperatures that are very different from their natural environment. In addition, unforeseen technical problems and equipment failures may arise which preclude successful cryopreservation of oocytes. Therefore, the possibility that all, some or none of the oocytes may survive the freezing and thawing process may occur, resulting, on some occasions, in the cancellation of a future assisted reproductive procedure.

3. FREEZE AND THAW SURVNAL

I understand that the probability of the oocytes' survival of the freeze/thaw procedure is approximately 60-80%. I acknowledge the possibility that none of my oocytes may survive the procedure and I am willing to take this risk.

4. BENEFITS OF OOCYTE CRYOPRESERVATION

Future Cycle(s). Cryopreservation of oocytes affords patients the possibility of initiating a successful pregnancy in future assisted reproductive technology cycle(s), which they may elect to participate in. Some women elect to freeze their eggs at a younger age for use at a later time in the future. Women who are faced with cancer or other diseases may choose to freeze their eggs before they undergo chemotherapy, radiation or other medical treatment. Some women who have do not respond very well to ovarian stimulation drugs may undergo several cycles to retrieve the few eggs that they produce and have these eggs frozen for future ART. Some patients may also opt to freeze their eggs if it is determined that uterine conditions are not optimal for embryo replacement.

Reduction of Risks of Multiple Births. Additionally, freezing and storing oocytes reduces the risk of multiple births in the patients' fresh NF cycle and therefore reduce the attendant medical (obstetric) risks to the mother in undergoing multiple deliveries in a single IVF cycle. This is because the patient and the doctor will have control on how many oocytes can be inseminated in any given cycle and subsequently control the number of embryos that may be placed back into the uterus without having to deal with excess embryos.

5. CONFIDENTIALITY

Any information obtained during these procedures that can be identified with me will remain confidential and will be described to individuals not connected to this project, only with my written permission. I understand that photographs or videotapes may be taken of my oocyte(s) during the cryopreservation procedures as a permanent record and for possible use at medical meetings or with the lay public for educational purposes. I understand that I have the right to review these records at any time. Furthermore, a government agency, including the FDA, may choose to review the research data at any time to ensure that the research protocol has not deviated from the accepted guidelines concerning research on human subjects. Any new information developed during the course of this investigation, which may affect my willingness to continue participation, will be promptly provided to me.

6. COMPENSATION OF PROCEDURE

I acknowledge and understand that the aforementioned procedure is still experimental in nature and all risks and discomforts may not be presently known. There is no provision made for me to receive compensation or medical treatment at GFS or my physician's expense for physical harm suffered by me as a result this procedure.

7. FURTHER INFORMATION

I appreciate the importance of carefully reading, studying, and understanding this consent form, and acknowledge that before I signed this form, I was given the opportunity to discuss the form and my questions about the cryopreservation procedure with my physician(s) and the staff of GFS. We also understand that my physician and staff of GFS will be available to answer any future questions I may have if J elect to participate in this project.

8. VOLUNTARY PARTICIPATION

I understand that the purpose of this consent form is to advice me as to my decision to participate in the Cryopreservation of Oocyte Program. I understand that participation in this project is voluntary, and will

neither prejudice nor harm my current or future status or relationship with my physician and GFS, nor result in any penalty or loss of benefits to which I am otherwise entitled.

9. STATEMENT OF HUMAN RIGHTS

I may withdraw my consent and discontinue participation in this project at any time without prejudice or penalty and loss of benefit as participants in the IVF program.

10. SUBSEQUENT OBSTETRIC AND POST-NATAL MEDICAL CARE

I understand that admission to and continued participation in this program requires that I take no medication other than that dictated by my doctor. Furthermore, if a pregnancy is established with the transfer of embryo(s) resulting from my thawed oocytes, close observation by my physician or his/her designee is important and will be conducted throughout the pregnancy. The removal of a sample of fluids surrounding the baby (amniocentesis) may be advisable at 14 to 16 weeks of gestation or, alternatively, the clinical procedure known as chorionic villi sampling at 8 weeks of gestation may be performed, depending on maternal age. These two procedures may alert my physician to certain potential chromosomal abnormalities or major structural abnormality. If this is discovered, a geneticist and our physician will discuss with me the implication of these findings; and I, as a patient, will make the decision whether or not the pregnancy should be continued. If I decide to terminate the pregnancy, I understand that the clinical and hospital costs and expenses incurred to that date, or resulting from that termination, will be borne by mes. I will assume total financial responsibility for the medical care provided to me and/or my infant(s).

11. UNDERSTANDING THIS FORM

I hereby acknowledge that I have read and fully understand the contents of this consent form. I acknowledge that all procedures described in the form have been adequately explained to my satisfaction and that I understand them. I have risks, benefits and alternatives and I have had adequate time to reach my decision and have reached my decision voluntarily. All of my questions have been answered to my satisfaction.

12. INDEMNIFICATION

I agree, along with my successors and heirs, to hold harmless, reimburse and indemnify GFS, and its affiliated and subsidiary companies, the owner(s) of the facility; our Physician(s) and their respective employees, contractors and agents for any loss, expense, cost or damage (including reasonable attorney's fees) paid or incurred by any member of the GFS that arises from a negligent or willful act or omission on my part, including, but not limited to, any failure by me to heed any warning, advice or recommendation or follow instructions, directions, or regimen given to me by any authorized member of GFS.

13. INSURANCE

I am advised that GFS and its agents, or any other agency, provides no insurance coverage, compensation plan, or free medical care plan to compensate me if my oocyte(s) are injured, harmed or destroyed by this cryopreservation procedure. I also understand that insurance coverage for the oocyte cryopreservation procedure is not available at this time, and that I will be responsible personally for all costs involved in the oocyte freezing. I have been provided with and have the current fee schedule for these procedures.

14. WAIVER

I acknowledge and understand that as with any technique necessitating mechanical assistance, equipment failure can occur. I agree that I shall not hold any member or members of GFS liable individually or jointly for any destruction, damage, any failure of utilities, any strike, cessation of services or other labor disturbance, any war, acts of public enemy or any other disturbance, any fire, wind, earthquake, water, act of God, or the failure of any laboratory that contracts with GFS for the provision of services.

15. COSTS

I acknowledge and understand that I am solely responsible for the cost of the cryopreservation of our oocyte(s). This fee includes the handling, cryopreservation procedure, and up to three (3) months of storage at the embryology laboratory of GFS located at 139 East 23rd St, New York, NY 10010.

After the first three (3) months, I understand and acknowledge that I am responsible for the storage fees until I decide to use the oocytes for future ART or donate the oocytes for research or dispose of the oocytes according to acceptable procedures. This fee schedule is subject to change without prior notification.

16. STORAGE TERMS

I acknowledge and understand that my frozen oocytess will be stored at GFS for up to the first three (3) months. This is to allow enough time to use the frozen oocytes in a succeeding cycle to achieve a viable pregnancy.

After the first three (3) months, I may elect to either: (a) transfer the frozen oocyte for long-term storage; (b) donate the oocytes for research; (c) dispose the oocyte(s) according to acceptable procedures as mentioned above; or (d) notify GFS to keep the frozen oocytes in the facility for a subsequent ART in the near future.

17. TRANSFER OF FROZEN OOCYTES

I acknowledge and understand that my frozen oocytes will be stored at GFS for up to three (3) months. After the first three (3) months have elapsed, I also have the option of transferring my frozen oocytes to another facility of my choice and I undertake the obligation of notifying GFS beforehand about such arrangements.

Furthermore, I understand and agree that I am responsible for the costs incurred in the transfer and further storage of my oocyte(s) at the facility of my choice. I also understand that I do not have to be physically present in the facility to witness the transfer of my frozen oocytes(s), however, I may elect to do so by notifying GFS.

18. DISPOSAL OPTIONS

I have the principal responsibility to decide the disposition of my oocyte(s). I understand that it is my responsibility to notify GFS of any change of address that I may have in the future and also to notify them as to how I want to dispose of the oocytes after its three (3) months of storage. I will send GFS a signed and notarized consent form in the event that J would wish GFS to discard our frozen oocytes. In the event that I cannot be contacted after reasonable attempts to reach me certified mail with return receipt and by phone), the following options should determine the fate of these oocytes:

A. In the event of my death
B. In the event that I no longer wish to attempt to initiate pregnancy
C. In the event that I cannot be located (lost contact) within at least one year.

The oocytes may be: (please initial your choices for each respective event above).

	Donated for Research	Discarded	Surviving Partner Decides	Other
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____
C.	_____	_____	_____	_____

1 understand that the current procedure utilized by GFS in the disposal of oocytes is by thawing the oocytes according to their thawing protocols and allowing the oocytes to ultimately degenerate in culture after which the oocyte(s) is/are discarded. I acknowledge that I can change my choices at any time by sending a written confirmation to GFS.

19. AUTHORIZATION

In light of careful consideration of the potential risks and benefits of oocyte cryopreservation and subsequent thawing, I, the undersigned, being of legal age, and desirous of having a child, hereby consent to participate in GFS's Oocyte Cryopreservation Program and voluntarily request, authorize and direct GFS, the facility, the Physicians and their respective employees, contractors and agents to perform any and all procedures necessary for oocyte cryopreservation, as well as any such additional procedures that any of them may deem necessary.

I understand that the interpretation and effect of this Consent for Oocyte Cryopreservation shall be governed by the laws of the state of New York.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Witness' Name	Signature	Date

BRAVERMAN
IVF & Reproductive Immunology, P.C.
Answers for Infertility & Recurrent Pregnancy Loss

CONSENT FOR OOCYTE RETRIEVAL VIA ULTRASOUND GUIDED TRANSVAGINAL OVARIAN CYST ASPIRATION

1. I, _____ (Patient's Name), authorize DR. _____or associates or assistants of his/her choice to perform upon me the following operations and/or procedure (please type or print and explain in plain English) ULTRASONICALLY GUIDED TRANSVAGINAL OVARIAN CYST ASPIRATION FOR OOCYTE RETRIEVAL, including such photographing, videotaping, televising, or other observation of the operation(s), procedure(s) as may be purposeful for the advancement of medical knowledge and/or education with the understanding that my/the patient's identity will remain anonymous.

2. DR. _____ has fully explained to me the nature and purpose of the operation procedure and has also informed me of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

3. I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above named physician or his/her associates or assistants may consider necessary.

4. I further consent to the administration of such blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with blood transfusions and that such risks have been fully explained to me.

5. I understand that immediately prior to surgery, anesthesia may be administered to me. Based upon the recommendations of my physician, I consent to the following:

☐ Local or regional anesthesia to be administered by the operating surgeon or his designee.
The risks and benefits of local or regional anesthesia have been explained to me. I understand that there is always the possibility that the local or regional anesthesia will need to be supplemented or replaced by general anesthesia.

☐ General or regional anesthesia to be administered by an anesthesiologist.

☐ No anesthesia.

6. I acknowledge that no guarantees or assurances have been made to me concerning the result intended from the operation or procedure.

7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs above that do not pertain to me.

_____	_____	_____
Date	Patient's Signature	Print Name
_____	_____	_____
Date	Witness' Signature	Print Name

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____	_____
Date	Physician Signature

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