North American Cryobank, Inc.

Registration Form

PATIENT INFORMATION:

Name: _____ Date of Birth (NACB Account#): ___/___/____

SSN: _____

Address: _____ City: _____

State: _____ Zip _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

May we contact you by email for information, billing or lab results? Yes or No (please circle one)

Email Address: _____

Partners Name: _____ SSN: _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Email Address: _____

Have you ever **tested positive** for HIV, Hepatitis B, Hepatitis C, HTLV-I or II, RPR? ☐ Yes ☐ No

If yes specify: _____

Privacy Policy: NACB requires a personal identification number (PIN) for release of information about your account. Please clearly print your PIN number now that you will remember _____

To whom, other than yourself, may NACB release information about your account?

_____ Name _____ relationship

PERSON RESPONSIBLE FOR THIS ACCOUNT (if other than self)

Name: _____ Relationship _____

Address: _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

SSN# _____

Referring Physician

Name_____ Phone#_____ Fax#_____

PAYMENT POLICY

Payment is due at time of service unless previous arrangements are made. We accept cash, checks and certain credit cards. Our office follows the Idaho Civil Code for all returned checks. The patient named above acknowledges that should collection become necessary, the patient agrees to be responsible for all collection costs and attorney fees to collect the amount for services rendered. Personal information such as Social Security Number (SSN) will only be used by our office to turn the account over to collection. The copy of the photo ID will only be used to verity and ensure that no one else can claim to be you to access your records. All information provided by you is used strictly by North American Cryobank**.**

PATIENT SIGNATURE BELOW IS REQUIRED

Your signature below acknowledges acceptance of our payment and privacy policies and agreement to keep NACB updated with your current address and contact information. After the billing interval assigned above, NACB will make one attempt to contact the patient via the address above. If there is no response by the patient or estate (in the case of death), then if any and all cryopreserved reproductive materials shall become the property of NACB to be disposed of by NACB or their delegates as solely and unilaterally determined by NACB management.

I, _____ am in agreement with all of the terms and conditions as listed above without recourse.

_____ Signature ___/___/___ date

2417 Bank Dr, Suite 14
Boise, ID 83705
208-985-0383

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information and to obtain your signature that you received this while on the day of service. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until further notice.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable federal law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit or it can be viewed in our office.

You may request a copy of our Notice at any time.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a medical record that is the physical property for North American Cryobank (NACB).

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to a physician, a group of physicians or medical practice, or other healthcare providers providing treatment to you for:

- The provision, coordination, or management of health care and related services by health care providers;
- Consultation between health care providers relating to a patient/customer;
- The referral of a patient for health care from one health care provider to another/or
- Appointment reminders

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:

- Billing and collection activities and related data processing;
- Actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provisions of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
- Medical necessity and appropriateness of care reviews, utilization review activities; and
- Disclosure to consumer reporting agencies of information relating to collection of payments

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:

- Evaluate the performance of our associates;
- Assess the quality of service, product and care in your case and similar cases;
- Learn how to improve our facilities and services;
- Conduct training programs or credentialing activities; and
- Determine how to continually improve the quality and effectiveness of the service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as Voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care

We may use of disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures, in the judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up a specimen, medical supplies, or other similar forms of health information.

Required by law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;

- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties; or
- To assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents

Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Government Functions

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information. This does not refer to fertility or any testing involved in your fertility care.

Workers Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Marketing Health Products or Services

We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

You're Authorization

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use you health information or to disclose to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those describe in this Notice.

You're Health Information Rights

Access

You have the right to review or get copies of your health information, with limited exceptions. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access b sending us a letter to the address at the end of this Notice setting forth the specific information to which your desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operation, where you have provided an authorization and certain other activities, for the last six years, but not for disclosures made prior to April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to theses additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication

You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice

If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

If you have any questions or complaints, please contact: Joe Richard, NACB, 2417 Bank Dr,B1 Boise, ID 83705 Phone 208-985-0383, email: diector@northamericancryobank.com

Thank you for entrusting NACB with your reproductive health services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ acknowledge that I have received a copy of North American Cryobank “Notice of Privacy Practices”. This Notice describes how North American Cryobank may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature or Patient or Personal Representative Date

_____

Relationship to Patient

2417 Bank Dr, Suite 14
Boise, ID 83705
208-985-0383

Medical History (1 of 1)

Patient Name: _____ Date of Birth: ___/___/____

TYPE OF TISSUE TO BE STORED (one medical form per specimen type)

☐ embryo(s) ☐ sperm ☐ egg(s)
☐ ovarian tissue ☐ testicular tissue ☐ other _____

☐ Pre-vasectomy	☐ Pre-Radiation Therapy	☐ Pre-surgery
☐ Pre-Chemotherapy	☐ IVF	☐ IVF back up
☐ Fertility Treatment	☐ Donation	☐ Used by a Friend
☐ Used by a Surrogate	☐ Used by a Gestational carrier	☐ Occupational Hazard
☐ Transgender	☐ Other _____	

Treatment History

☐ Vasectomy ☐ chemotherapy ☐ Radiation ☐ Surgery ☐ None

Fertility History

Number of pregnancies _____ Number of live births _____

Comments:

_____

Your signature below acknowledges that the reproductive materials and or specimens provided to NACB for the purposes of long term storage have been produced and are the property of the undersigned. It is understood and agreed that future serology testing may be required for storage and or release of these specimens.

Signature _____ date ___/___/___

If the patient above is a minor, a parent or guardian of the minor must sign below:

_____ Signature parent or guardian if applicable

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Reproductive Material Cryostorage Agreement (1 of 4)

This AGREEMENT, made between North American Cryobank, Inc (NACB) and the person named below (the Client).

1. **Collection and Storage**: With the assistance of the Client, and in accordance with the procedures for identification and testing established by the Company as set forth by the company, the Company shall receive the clients reproductive materials, which has already been cryopreserved by the Clients physician/clinic (the "Clinic"), for long-term cryostorage until the Agreement is terminated pursuant to Paragraph 4. All procedures established by the company may be modified at the sole discretion of the company to reflect changes in industry practices, laws or regulations.
2. **Storage Fees and Records**: The fee for each storage period shall be payable in advance and shall be adjusted from time to time by the Company based upon market factors. The current fees are set forth in the company's policy manual. A storage period begins with the month in which the Company receives the specimens for storage. Unused storage fees are non-refundable. The client shall keep the Company informed within 10 days of a change, of his or her current address and phone number for billing purposes and any other matter requiring notice to the Company. The Client's name and address, as well as other records relating to the subject of this Agreement, shall be kept on file at the Company.
3. **Account in Default:** If at any time, the Company has not received full payment of all amounts due to the Company from the client on or before 30 (thirty) days after the beginning of any storage period, then the Client is in default. In the event of a default, the company may at its sole discretion refer the Client's account to any attorney or collection agency for collection and the Client agrees to pay all costs of such collection, including but not limited to any reasonable fees charged by the collection agency and reasonable attorney fees. The Company may at its sole discretion make one attempt to contact the patient via the address above. If there is no response by the patient or estate (in the case of death), then any and all cryopreserved reproductive materials shall become the property of NACB to be disposed of by NACB or their delegates as solely and unilaterally determined by NACB management. The term "discard or dispose of" means that the Company will thaw and destroy the specimens in a professional and ethical manner as determined solely by the Company. Discarded specimens cannot and will NOT be used for reproductive purposes on or behalf of any person or persons.
4. **Termination of this Agreement**: This Agreement shall terminate and the Company's responsibilities for storage of specimens hereunder will cease:
    a. upon the release of all specimens stored by the Company pursuant to conditions of release; or,
    b. upon the disposition of all specimens stored by the Company pursuant to a default under Paragraph 3; or,
    c. upon the notarized execution of Company's separate termination agreement by the Client or his Surviving Spouse; or
    d. Upon receipt of a certified copy of the death certificate, if the client dies without leaving a surviving spouse.
5. **Responsibilities and Liabilities of the Company**: The Client acknowledges that he or she has been fully advised concern the site of the art of cryopreservation of any and all specimens. The Client acknowledges that he or she understands that the viability of the reproductive materials

and the results from subsequent fertility attempts depends almost in their entirely upon the client and the recipient. Accordingly, the Client understands and agrees that the Company's responsibilities shall be limited hereunder solely to the adequate cryostorage of said specimens consistent with the state of the art at the date of entering into this Agreement. The Client agrees to hold the Company harmless for any damages sustained while the reproductive materials are not in the possession and control of the Company. In any event, the total liability of the Company for failure to meet any of its responsibilities to the client shall not exceed the amount of storage and or shipping fees theretofore paid by the client. The parties agree that any claims relating to arising out of this agreement will be brought to arbitration in the State of Idaho. In the event the Company terminates the operations of its storage facility, it may 30 days after written notice to the client at his last known address, assign and transfer its obligations hereunder and the specimens held on behalf of the client to a similar storage facility.

6. This document and any directive agreements are considered to be legal documents that describe your intentions regarding the transfer, storage, use, disposition or destruction of your reproductive materials. YOU ARE ADVISED TO CONSULT WITH YOUR ATTORNEY to prepare a tissue directive. Our forms used in the event of non prepared forms **do not constitute providing any legal advice.** NACB strongly urges you to independently consult with a knowledgeable reproductive attorney regarding any directives.
7. **Additional Terms**: The client promises and agrees to indemnify and save harmless the Company and its officers and employees from any loss and or expenses incurred with the defense or payment of any claim by any other party relating to the subject of this Agreement. The Agreement shall be binding upon the client and his assigns, heirs, executors and administrators.
8. **CONDITIONS OF RELEASE OF CRYOPRESEVERED REPRODUCTIVE MATERIALS from Storage during lifetime of Client:** Release of cryopreserved reproductive materials may occur during the lifetime of the client, only upon the occurrence of the following conditions;
    a. only to a licenses physician, and
    b. only for use by the client's spouse or sexually intimate partner (Recipient),
    c. upon the express notarized authorization of the client, and
    d. upon the authorization of the Recipient's clinic, and
    e. Upon the completion of serology/virology tests required by the Company.

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9. **Advanced Directives for Cryopreserved Reproductive Materials in the event of Death of Client:** If the Client is a minor, this Advanced Directives section does not need to be completed. When the Client is an adult and or marries, NACB strongly recommends completing a new cryopreserved reproductive materials agreement including the Advanced Directive section.
    a. **If the Client is NOT Married at the Time of his/her death**, the client directs that his/her reproductive materials can be discarded, upon receipt by the Company of a certified copy of the death certificate, unless prior to death that the Company has received from the Client a written and notarized notice (NACB form) signed by the client identifying their intimate sexual partner and directing that they take control and responsibility of the reproductive materials. It may be used by the intimate sexual partner for the purpose of procreation, upon the written notarized acceptance of an agreement to be bound by the terms of this Agreement.

    b. **If the client is married at the time of death**, the client directs the following disposition for the reproductive materials, upon receipt by the Company of a certified copy of the death certificate:

CHOOSE ONE of the following by marking your choice with a check and signing and dating below your choice.

☐ **A:** The Client directs that the reproductive materials shall become the property of the surviving partner and may be used for his /her purposes of procreation, upon their written and notarized acceptance and of agreement to be bound by the terms of this Agreement.

_____ ___/___/___
Client date

~OR~

☐ **B:** The Client directs that the reproductive materials be discarded.

_____ ___/___/___
Client date

By my witnessed signature below, I acknowledge that I have read and understand the terms of this agreement. I acknowledge that I further understand that my cryopreserved specimens cannot be used in the event of my death unless all conditions in section 7, conditions of release and section 8 advanced directives are completed.

By: _____ _____ ___/___/___
Print name signature date

If the patient above is a minor, a parent or guardian of the minor must sign below:

By: _____ _____ ___/___/___
Print name of Parent or Guardian signature date

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The undersigned Witness affirms that they know the Client and or Parent/guardian, if applicable, and that he/she was present and witnessed the Client signature and Parent/Guardian on this document

By: _____ _____ ___/___/___
Print name of Witness signature date

By: _____ ___/___/___ NACB Account: _____
NACB representative date

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PAYMENT POLICY for REPRODUCTIVE MATERIALS (1 of 1)

Please indicate the billing interval for stage fees that you elect. Unused storage fees are non-refundable. Storage and shipping fees must be prepaid.

☐6 months	☐One Year	☐Two Years	☐Three Years	☐Five Years	☐ Other
$ 250	$ 375	$ 650	$ 825	$ 1200	$_____

Credit Card Authorization: Your signature here authorizes NACB to charge your credit card for shipping and storage fees. ☐ Check here if you are only authorizing NACB to use your credit card for the first annual or multi-year storage period and the shipping fees.

Signature: _____ Date: ___/___/___

Account Number _____ Name on Card _____

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Expiration: Mo____/Year ____ Security Number _____ Billing Zip: _____

Your signature below acknowledges acceptance of our payment and privacy policies and agreement to keep NACB updated with your current address and contact information. After the billing interval assigned above, NACB will make one attempt to contact the patient via the address above. If there is no response by the patient or estate (in the case of death), then any and all cryopreserved reproductive materials shall become the property of NACB to be disposed of by NACB or their delegates as solely and unilaterally determined by NACB management.

I, _____ am in agreement with all of the terms and conditions as listed above without recourse.

_____ Signature ___/___/___ date

If the patient above is a minor, a parent or guardian of the minor must sign below:

_____ Signature parent or guardian if applicable

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