MONTGOMERY FERTILITY CENTER

COVID-19 CONSENT FOR FERTILITY TREATMENT

This Acknowledgement Regarding COVID-19 (this "***Acknowledgement***") applies to all treatment(s), procedure(s) or service(s) (the "***Services***") I, the patient, and my partner, as applicable, will receive from Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) indicated below.

Acknowledgement Regarding COVID-19

._____(Initial) I/We acknowledge that I/we have discussed the implications of COVID-19 with my/our clinical team, have had an opportunity to ask questions and have asked the questions that I/we have.

._____(Initial) I/We understand that information regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that risk may come to light of which Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) is presently not aware. . At this time, there is limited information about COVID-19, particularly related to its effect on pregnant women or developing fetuses. At the present time, there are no recommendations specific to pregnant women regarding the evaluation and management of COVID-19.

._____(Initial) I/We acknowledge that the guidance from the Center for Disease Control and Prevention ("***CDC***"), the American Society for Reproductive Medicine ("***ASRM***"), the World Health Organization ("***WHO***"), the American College of Obstetricians and Gynecologists ("***ACOG***"), and the Society for Maternal Fetal Medicine ("***SMFM***") may change at any time based on new information regarding COVID-19.

._____(Initial) I/We further understand that the medical experts have still not determined what risks, if any, COVID19 might have on patients undergoing infertility treatment or patients who become pregnant. Although there is no current evidence of maternal-fetal transmission of COVID-19, data is limited and prior data support that a febrile illness of any kind in pregnancy may pose risks including miscarriage, stillbirth, and preterm birth. Further, medications to treat COVID-19 are not currently tested/approved in pregnancy.

._____(Initial) I/We further understand that there is very little known regarding a pregnant woman's susceptibility to catching COVID-19 or experiencing severe symptoms or dying. The currently available data on COVID-19 does not indicate that pregnant women are at increased risk. However, pregnant women are more susceptible to and at greater risk of mortality and complications from other respiratory infections such as influenza and SARS.

._____(Initial) I/We further understand that there is little known regarding the impact of COVID-19 on pregnancy. Prior data suggest that high fever in early pregnancy may be associated with an increased risk of birth defects and miscarriage. Some infections in later pregnancy may result in stillbirth and preterm birth.

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._____(Initial) I/We further understand that adverse infant outcomes including pre-term birth have been reported among infants born to mothers positive for COVID-19 during late pregnancy. However, this information is based on limited data and it is not clear whether these outcomes were directly related to maternal infection or not. Currently, it is unclear if COVID-19 can cross the placenta to directly harm the fetus. Although it is unclear what the optimal medical treatments are for this infection, a variety of medications are used to combat the illness. It is possible some of these medications may cause harm to the pregnancy or fetus.

._____(Initial) I/We further understand that the risks of COVID-19 on pregnancy, if any, are unknown but could include, birth defects, miscarriage, stillbirth, preterm birth or other pregnancy complications.

._____(Initial) I/We further understand that my treatment cycle may be cancelled if new data arises that mandates cancellation of treatment for the safety of me or my future pregnancy or of clinic staff.

._____(Initial) I/We further understand that I may become exposed to COVID-19 while receiving treatment by other patients or a Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC provider.

._____(Initial) I/We further understand that if I/we elect to proceed with Services that may result in a pregnancy, at any point during my/our cycle should any COVID data change, THE CYCLE MAY BE CANCELED.

._____(Initial) If your cycle is canceled, you may incur additional expense for medications. You will be responsible for additional administrative fees **(non-refundable)** of **$250** upon resumption of treatment.

._____(Initial) Should the medical experts put forward a statement prohibiting or setting forth contraindications to infertility treatment and/or pregnancy, Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) will follow such guidance and will not proceed with any cycle which may result in a pregnancy.

._____(Initial) I/We further understand that there may come a point where Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) may not be able to support treatment cycles (e.g, illness of doctors or laboratory staff which would prevent Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) from rendering services, or Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) being required to shut down pursuant to a government order).

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._____(Initial) I/We understand that I/we might have been or may become exposed to COVID-19 prior to or while receiving Services by Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC).

._____(Initial) I/We understand that despite the measures that Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) is taking I/we may become exposed to COVID-19 during my/our treatment with Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) or on account of such treatment.

._____(Initial) I/We understand that, at the present moment, the availability of testing is limited and that Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) does not have access to testing for COVID19 for all its patients. **Nevertheless, Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) require patients to have at a minimum Sar CoV-2 antibody test done prior to initiation of treatment.** The test if **negative must be repeated in 2 weeks** and noted to be negative. If Antigen test is done the treatment can begin if negative.

._____(Initial) I/We understand Testing must be **repeated every 2 weeks during treatment cycles**. If at anytime the test become positive, the cycle will be canceled.

._____(Initial) I/We further understand that should I/we be directly exposed to COVID-19, be diagnosed with COVID-19, or become symptomatic with any febrile illness which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), **my/our treatment cycle will be cancelled**.

._____(Initial) I/We further understand that my/our treatment cycle may be cancelled if Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) is not able to support treatment as a result lack of essential staff or supply shortages

._____(Initial) I/We further understand that I have the option to postpone treatment in order to minimize the potential risks delineated above.

._____(Initial) I/We understand that should the treatment cycle be canceled **for any reason(s),** I/We may have additional cost related to medication costs (paid to the pharmacy) and **an additional(non-refundable) $250 administrative fee** upon resumption of treatment once 1/We have tested negative.

I/We I/We have discussed the risks and implications of COVID-19 with my physician, have had an opportunity to ask questions and have them answered to my satisfaction. I understand that information

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regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that additional risks or considerations may come to light.

By my/our signatures, below I/We confirm that I/we have read the above, information on COVID-19, have had an opportunity to discuss this information and our treatment plan with the treating physician, and agree to continue fertility treatment, including ART (if indicated) at this time.

Patient	**Partner**
Signed: _____	Signed: _____
Name: _____	Name: _____
Date: _____	Date: _____

Consent reviewed for completeness and signature/s: NOTARIZE

_____ _____

Notary Public Date

The patient and partner, as applicable, have been informed and counseled by me and others regarding the risks, if any, COVID-19 might have on patients undergoing infertility treatment or patients who become pregnant. The patient and partner, as applicable, appeared capable of understanding the information presented as demonstrated by our discussion and the responsive nature of the participation of the patient and partner, as applicable.

_____

Physician or Nurse Practitioner Signature Date