AMERICAN **FERTILITY**
SERVICES

CONSENT FOR FERTILITY TREATMENT DURING THE COVID-19 PANDEMIC

Please read the following "Consent for Fertility Treatment During the COVID-19 Pandemic" carefully. If you do not understand the information provided or do not feel comfortable with the information provided to you by AMERICAN FERTILITY SERVICES, or if you have any additional questions, please do not sign this consent before speaking with your treating Provider.

This Consent must be signed by both the Patient and any spouse or partner of yours (if applicable) with **PICTURE IDs** in the presence of an AMERICAN FERTILITY SERVICES staff member. If either is unable to sign the Consent in the presence of an AMERICAN FERTILITY SERVICES staff member, the individual's signature must be **notarized,** and the signed Consent, including the notary page, returned to and maintained at AMERICAN FERTILITY SERVICES.

Unless the context otherwise requires, references to "you" and "your," or "I," "me," or "my" in this Consent refer to both you and, if applicable, your spouse or partner. All sections of this Consent must be completed. This signed Consent will be maintained at AMERICAN FERTILITY SERVICES and will remain in effect indefinitely unless you rescind or jointly execute a new Consent to replace it, which may be done any time at your request. This Consent is an important document; you should keep a copy of this fully executed Consent for your records.

To be completed by AMERICAN FERTILITY SERVICES staff:

_____ _____

Patient Name **Spouse/Partner (if applicable) Name**

_____

AFS Patient Identifier

_____

Date Provided to the Patient

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COVID-19 is a rapidly evolving pandemic and, currently, information regarding COVID-19 infections that occur during pregnancy is limited. At this time, it is unknown whether pregnant women have a greater chance of getting sick from COVID-19 than the general public, or whether they are more likely to have a serious illness as a result of an infection. However, pregnant patients are more susceptible to, and at greater risk of morbidity and mortality, from other respiratory infections such as influenza and SARS-CoV-1. In addition, prior data suggest that some illnesses that are accompanied by fever during pregnancy may be associated with an increased risk of birth defects, miscarriage, stillbirth, and preterm birth.

In a limited number of small studies, maternal infections of COVID-19 during late pregnancy do not seem to cause adverse outcomes in newborns, and none of the infants tested positive for COVID-19. However, the effects of COVID-19 during early pregnancy have not been adequately studied, and newborns are still at risk of person-to-person infection after birth.

It is currently unknown what medications can be used to reduce the severity of COVID-19 symptoms. It is possible some of these medications may be contraindicated in pregnancy.

By signing below, I agree to the following statements and hereby release AFS from any liability in connection therewith:

1. At the present time, American Fertility Services (AFS) does not have access to testing for COVID-19 and may not have access to adequate testing for the foreseeable future.
2. I understand the COVID-19 virus has a long incubation period of up to 14 days, during which time carriers of the virus may not show symptoms but can still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in COVID-19 testing.
3. I understand it is possible that an AFS provider or staff member, or another AFS patient or family member, may be a carrier of COVID-19 and may expose or infect me with the virus.
4. If I am directly exposed, infected, or diagnosed with COVID-19, or have been in close contact with (within 6 feet) anyone exposed, infected, or diagnosed with COVID-19, or have symptoms associated with COVID-19 (which might include fever, chills, shortness of breath, loss of sense of taste or smell, dry cough, sore throat, muscle pain, or fatigue or tiredness) or have any other flu-like symptoms that could possibly be COVID-19 (even in the absence of a positive COVID-19 test), I will cancel my treatment cycle and refrain from entering AFS's facility for any purpose.
5. I understand that my treatment cycle may be cancelled if AFS is not able to continue treatment as a result of lack of essential staff or supply shortages.

6. I understand that my treatment cycle may be cancelled if there is change in regulations at the local, state, or federal level such as an executive order to stop providing services or procedures, or AFS is required to shut down for any other reason related to COVID-19.
7. The risks of COVID-19 on pregnancy are unknown but could include, and are not limited to, birth defects, miscarriage, stillbirth or preterm birth.
8. The American Society of Reproductive Medicine (ASRM) recommended the suspension of all new treatment cycles during the COVID-19 pandemic on March 17, 2020. Updated ASRM guidelines issued on April 24, 2020 lifted the moratorium.
9. I understand my treatment cycle may be cancelled if, during treatment, new data arise that mandate cancellation of treatment for my safety or the safety of my future pregnancy.
10. I verify that I will not enter the AFS facility or initiate fertility treatment at AFS if I have traveled or resided outside the United States in the preceding 14 days.
11. I verify that I will not enter the AFS facility or initiate fertility treatment at AFS if I have traveled domestically within the United States by commercial airline, bus, or train within the preceding 14 days.
12. I verify that I will not enter the AFS facility or initiate fertility treatment at AFS if I have not been following social distancing practices of at least 6 feet for a period of 14 days prior to entering the facility or prior to the initiation of fertility treatment at AFS. I will at all times follow such practices and/or take such other measures as are recommended by the CDC and/or local department of health, as long as recommended by the CDC and/or local department of health.
13. I verify that I will not enter the AFS facility or initiate fertility treatment at AFS if I have had any of the following symptoms in the preceding 14 days: fever, chills, shortness of breath, loss of sense of taste or smell, dry cough, sore throat, muscle pain, or fatigue or tiredness.
14. I verify that I will not enter the AFS facility or initiate fertility treatment at AFS if I have been in close contact (within 6 feet) with anyone who has had any of the following symptoms in the preceding 14 days: fever, chills, shortness of breath, loss of sense of taste or smell, dry cough, sore throat, muscle pain, or fatigue or tiredness.

I understand that, if a treatment cycle is cancelled for any reason, including but not limited to the statements above, this may affect my insurance benefits and/or I will be financially responsible for any and all services already performed, including any medication expenses incurred. I acknowledge and agree that AFS will only refund that portion of any deposit or other prepaid amount in excess of amounts necessary to cover services already performed by AFS.

I have discussed the implications of COVID-19 with my provider, and have had an opportunity to ask questions and have them answered to my satisfaction. I understand that information regarding COVID-19 and the medical community's understanding of this disease is rapidly evolving, and risks may come to light of which they and I are presently not aware. I have read this document in its

entirety and have had ample time to reach my decision, free from pressure and coercion, and agree to proceed with treatment during the COVID-19 pandemic.

_____	_____
Signature- Patient	**Signature – Spouse/Partner (if applicable)**
_____	_____
Printed Name - Patient	**Printed Name -– Spouse/Partner (if applicable)**
_____	_____
Date	**Date**

WITNESS SIGNATURES

_____	_____
Patient's Witness - Print Name and Title	**Spouse/Partner's Witness – Print Name and Title**
_____	_____
Patient's Witness - Signature	**Spouse/Partner's Witness – Signature**
_____	_____
Date	**Date**

PICTURE IDENTIFICATION

Patient:

Type: _____ Exp. Date: _____

Spouse or Partner (if applicable):

Type: _____ Exp. Date: _____

Picture Identification(s) Confirmed on Date: _____/_____/_____

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NOTARIZATION

(If not signed in the presence of an AMERICAN FERTILITY SERVICES Staff Member, your signature must be notarized.)

Notary Public for Patient's Signature

Sworn and subscribed to me on this _____ day of _____, 2_____

X_____ _____

Notary Public **Date**

Notary Public for Partner/Spouse's Signature

Sworn and subscribed to me on this _____ day of _____, 2_____

X_____ _____

Notary Public **Date**

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