We, _______________________ and ________________________, hereby certify that we have chosen, freely and after careful deliberation, to have our frozen embryos transferred in a Frozen Embryo Transfer (FET) cycle. Our providers have discussed with us the FET procedure and we have read thoroughly the portions of the in vitro fertilization (IVF) Procedure Description that apply to FET cycles. We understand that risks exist to ourselves and to the frozen embryos regardless of the skill of the physicians and staff involved in the procedure and regardless of the level of care used in administering the procedure. We have had full opportunity to discuss the program and its risks with a physician. The alternatives available to us in lieu of FET have been fully explained and are understood by us.

In requesting that we be permitted to participate in an FET cycle, we understand and agree, jointly and severally, that:

1. Our physicians have reviewed with us to our satisfaction the risks, benefits and current success rate statistics for FET.

2. We understand that, in addition to the risks of injury to the woman and to any child conceived through FET, there may be situations in which fertilized eggs (pronuclear embryos or embryos) will be allowed to die rather than being transferred to the woman. We authorize the members of the assisted reproductive technology (ART) Program staff to take actions with regard to our embryos according to FET protocol or otherwise in accordance with accepted medical principles and procedures.

3. We understand that the risk of having a child with a birth defect is 3% in the general population (without using FET). Some recent evidence suggests that IVF and/or embryo freezing procedures may somewhat increase this risk. We thus cannot rule out the possibility that a birth defect will follow from use of these procedures. We understand that, regardless of the condition of the baby, we would be responsible for the care of any child born of these procedures.

4. We realize that an FET cycle is a precisely timed procedure which relies heavily upon patient participation and cooperation. Patients are required to appear for a variety of tests and procedures, and in all cases it is their responsibility to arrive at the designated location at the assigned times.

5. We understand that the Dartmouth-Hitchcock Medical Center, its component institutions, and the ART Program do not provide financial compensation or reimbursement for medical care in the event that our participation in the ART Program results in physical or psychological injury. In the event that either of us incurs such an injury, the ART Program staff will assist us in gaining access to appropriate treatment, but we agree that we will remain responsible for the cost of such treatment.

6. We agree to assume full responsibility for all costs incurred by us as a result of our participation in the ART Program. We understand that the costs associated an FET cycle are billed according to services rendered and will vary according to the circumstances. We have discussed the factors that may affect cost with a representative of the Business Office of the Mary Hitchcock Memorial Hospital or the Dartmouth Hitchcock Clinic. We understand that most health insurance plans will not cover these costs, and we assume responsibility for determining what portions of treatment, if any, our insurance will cover and for arranging payment.
7. We hereby release the Dartmouth-Hitchcock Medical Center, its component institutions, and internal committees, and their successors (including, without limitation, The Dartmouth Hitchcock Clinic, the Mary Hitchcock Memorial Hospital, the Dartmouth Medical School, the Mary Hitchcock Memorial Hospital Ethics Advisory Committee, and the ART Program) and all physicians, staff personnel and other individuals connected in any way with the ART Program from all common-law, statutory or other liability of any kind for injuries of any kind -- whether physical, mental, emotional, monetary or other -- suffered by either of us, by any child born to us as a result of any ART procedures, or by any pronuclear embryo, embryo or fetus conceived as a result of these procedures, except that no individual or institution shall be released from liability for injuries that occur as a result of gross negligence or intentional misconduct by that individual or institution. We also specifically (but without limitation) release all such individuals and institutions from any liability whatsoever for our failure to achieve pregnancy through the use of the FET procedures, for allowing to die those embryos (whether or not fertilized and dividing) which are not transferred back to the woman for any reason. We acknowledge that the FET procedure has inherent risks which we are assuming. We are asking to participate in the FET Program by choice, not because the treatment is, in any sense, medically required for either of us and not because we have been urged to participate by any physician or other individual connected with the Dartmouth-Hitchcock Medical Center.

8. We agree to indemnify (reimburse for losses and expenses) the Dartmouth-Hitchcock Medical Center, its component institutions, the ART Program, the Mary Hitchcock Memorial Hospital Ethics Advisory Committee, and any physicians, staff personnel, or other individuals connected with the ART Program in connection with any liability, including costs and reasonable attorneys' fees, incurred:

   (a) as a result of any misrepresentation by either of us to ART Program staff regarding our age, marital status, or other relevant facts; or

   (b) in connection with any claim by or on behalf of any pronuclear embryos, embryos, fetuses, or children conceived or born as a result of the FET procedure, except any claim based upon gross negligence or intentional misconduct in connection with the *in vitro* fertilization or embryo freezing process.

9. We agree that we each accept all of the legal rights and responsibilities of parenthood with respect to any child born to the female participant whose signature appears below as a result of our participation in the ART Program, including responsibility for child support. We both expressly agree that the male participant whose name and signature appear below shall be the legal father of any child born to the female participant as a result of our participation in the ART Program and that the female participant shall be the legal mother of that child.

10. I hereby certify that (place initials next to applicable statements):

   [Female]  [Male]
   _____  _____ I am married to the person who, along with me, has signed this document.
   or
   _____  _____ I am unmarried.

11. We hereby certify that we have read this release and the accompanying information. Our questions regarding the rights that we have retained and the rights that we have waived have been answered to our satisfaction. If we have further questions, we understand that we may discuss them with the ART Program staff.
PARTICIPANTS’ REQUEST FOR PARTICIPATION
AND RELEASE
IN A FROZEN EMBRYO CYCLE

12. We understand that this consent form is good for procedures done for a FULL YEAR from the date of our
signatures. We further understand that it is OUR RESPONSIBILITY to NOTIFY the DHMC ART Program of any
changes in our marital status that could lead us to desire that this consent no longer be in effect.

13. We understand that the 1992 Fertility Clinic Success Rate and Certification Act requires that CDC collect data
on all assisted reproductive technology cycles performed in the United States. We further understand that in
order to comply with this requirement, DHMC will report all ART cycles to a national registry maintained
under HIPAA compliant policies, by the Society for Assisted Reproductive Technology (SART). Information
from this database is reported to the Centers for Disease Control.

14. We agree to keep the ART Program staff informed of the outcome of our participation. If we do achieve a
pregnancy, we give permission for the ART Program to contact our obstetrician to obtain birth information.

15. We would like to do the following, however we understand that our preference may not always be followed
and that another course of action may be decided on by the ART Program Staff (Choose one):
[ ] Do a day 3 transfer thawing the fewest possible number of embryos thereby getting greatest possible
number of frozen cycles
[ ] Do a day 3 transfer and thaw all remaining embryos
[ ] Do a day 5 transfer thawing as many as needed (note: this could mean thawing all remaining embryos)
[ ] Other ___________________________________________________________
[ ] Have the ART Program Staff decide these things

16. _____ We agree to the transfer of up to ___________ embryos per cycle.

_______________________________________________            ______________________________________________
Signature of Patient                           Signature of Spouse/Partner

I have reviewed the risks and benefits of the IVF procedure with the participants.

______________________________________          __________________________________________
Signature of Physician                                                                 Date                           Time            (All Signed)

TRANSlator - If the translator is necessary and physically present, please request a signature below:

___________________________________________         __________________________________________
Signature of person translating information for patient            Date                                            Time

If translation is done using a commercially available language line, identify the name of the translator and the commercial
service.

___________________________________________         __________________________________________
Name of individual translating information for patient              Date                                            Time

Name of commercial services vendor

Health Information Services Approval; 4-11-2012