AUTHORIZATION FOR EMBRYO OR OOCYTE CRYOPRESERVATION

OFFICE USE ONLY:

_____

_____

_____

_____

Patient Name: _____

Patient D/O/B: _____ MPI #: _____

[adhere patient labels here]

Partner Name: _____

Partner D/O/B: _____ MPI #: _____

Billing Contact: ☐ Patient ☐ Partner Preferred Phone Type: ☐ Home ☐ Work ☐ Cell

Phone Number: _____

If Cryopreservation services are needed, I/we agree to pay the Cryopreservation Fee of $1,200 for any embryos or oocytes cryopreserved during this cycle. ***I understand that I must provide payment or payment information below to allow for the Cryopreservation of my embryos or oocytes.* Furthermore, I understand that I will not be charged a Cryopreservation fee if Cryopreservation services are not needed.*** I understand that my storage fee for the first year has been waived and that the storage fee for subsequent years is $720 ($780 for infectious) per year and is subject to change.

Patient Signature: _____ **Date:** _____

Partner Signature: _____ **Date:** _____

OR

I/We choose NOT to Cryopreserve any surplus embryos.

Patient Signature: _____ **Date:** _____

Partner Signature: _____ **Date:** _____

I, the undersigned cardholder, authorize CryoVault to debit my credit card identified below for payment due of Cryopreservation Fees on the date that service is provided and according to the terms described above.

**PAYMENT OR CREDIT CARD INFORMATION IS REQUIRED*

Billing Address: _____

City, State, Zip: _____

Credit Card #: _____ _____ _____ _____

☐ Visa
☐ MasterCard
☐ Discover
☐ American Express

Expiration Date: _____ / _____ Billing Zip Code: _____

Cardholder Printed Name: _____

Cardholder Signature: _____ Date: _____

Revised: 10-Jul-2018