Bethesda Fertility Center

# CONSENT FOR FERTILITY TESTING & TREATMENT DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic is a rapidly evolving global public health emergency. COVID-19 is the name of the clinical disease and SARS-CoV-2 is the novel coronavirus that causes COVID-19. Currently, little is known about the impact of the SARS-CoV-2 virus on human reproduction and pregnancy.

It is important that you stay connected with your healthcare provider(s) throughout your fertility treatment and pregnancy. They will be able to update you on any new information as it becomes available. You may also access information regarding COVID-19 and pregnancy through the website of the Centers for Disease Control and Prevention (CDC):
cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html

By signing below, I/we agree to the following statements:

1. If I/we are directly exposed, infected or diagnosed with COVID-19, or have symptoms (febrile illness or have flu like symptoms that could possibly be COVID-19), I/we will immediately report this to the Bethesda Fertility Center (BFC). I/we understand that BFC may choose not to continue testing and/or treatment under such circumstances.

2. My/our testing and/or treatment cycle may be cancelled if there are changes in local, state or national policies and regulations that require BFC to stop providing patient care.

3. My/our testing and/or treatment cycle may be cancelled if BFC is not able to provide care due to lack of essential medical personnel, medications or medical supply shortages.

4. I/we understand future studies may inform us of specific pregnancy complications in the setting of SAR-CoV-2 exposure/infection during pregnancy that are currently unknown.

5. I/we understand that my/our treatment may be cancelled if, while undergoing treatment, new studies or data advise cancellation of treatment for my safety or for the safety of a future pregnancy.

6. I/we will practice social distancing and risk reduction for exposure to SARS-CoV-2 virus at all times as recommended by local, state or national authorities.

7. I will wear a facemask at all visits at BFC.

8. I/we understand that only the actual patient who has an appointment and one support person over the age 0f 18 may enter BFC at this time.

9. I/we have been informed that the American Society of reproductive Medicine (ASRM)

provides guidance regarding the practice of reproductive medicine. Regarding COVID-19, ASRM provides that national, regional, state, and municipal regulations dictate what is and is not permitted, but ASRM recommends the following:

- A sustained reduction in the number of COVID-19 cases in Greater Cincinnati area for at least 14 days.
- Education and staffing training.
- Documented risk mitigation plan for each procedure.

Having fulfilled the ASRM recommendation and in accordance with Governor DeWine and Dr. Action's order, BFC is scheduling fertility testing and treatment with the required and recommended safety precautions in place but reserves the right to revise risk mitigation plans at any time. Additional safety measures or the reduction or cessation of services may be required.

10. If for any reason my/our treatment cycle needs to be cancelled, I/we understand that I/we would be responsible for the costs of actual services provided By BFC and for the costs of any medications used during treatment.

The following options have been discussed:

1. Deferring or stopping fertility testing and/or treatment at this time
2. Avoiding pregnancy until such time as we have more information on the SAR-C0V-2 virus
3. Proceeding with or continuing fertility testing and/or treatment at this time

I/we understand that I/we are proceeding with treatment at a time where limited information is known on the effects of the SAR-C0V-2 virus on reproduction and pregnancy.
I/we have been counseled by a physician regarding the information contained in this document. I have had the opportunity for all of my/our questions to be answered to my/our satisfaction. I/we are electing to proceed with treatment at this time.

______________________________________ ___ /___ /_____

Patient Name Birth Date

______________________________________ ___ /___ /_____

Patient Signature Date

______________________________________ ___ /___ /_____

Partner Name Birth Date

______________________________________ ___ /___ /_____

Partner Signature Date