NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

This Notice of Privacy Practices is being provided to you on behalf of Seattle Reproductive Medicine with respect to reproductive medical services provided at Seattle Reproductive Medicine's facilities (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights

Although your health record is the physical property of Seattle Reproductive Medicine, you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your healthy information to your health insurer for services for which you pay "out of pocket" in full
- transmit copies of your health information to third parties when requested by you, in writing

Our Responsibilities:

We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at www.seattlefertility.com as well as at our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice.

We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

Permitted Uses and Disclosures

*We will use and disclose your health information for **treatment**. For example:* information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*We will use and disclose your health information for **payment**. For example:* A bill may be sent to you or a third party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

*We will use and disclose your health information for our **health care operations**. For example:* Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

Other Uses or Disclosures of Protected Health Information

Business Associates: There are some services provided at Seattle Reproductive Medicine through contacts with business associates. For example: certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payor for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact:
SRM, Executive Director: (206)301-5000. This information also available on our website at www.seattlefertility.com.

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

FINANCIAL POLICY

This statement describes your financial responsibilities as a patient at Seattle Reproductive Medicine (SRM). Please direct any questions you may have to our Finance Department.

Financial Counselors: As a patient of SRM, our team of financial counselors are available to assist with the financial elements of your fertility journey. These services consist of, but are not limited to the following:

- Providing clarity and information related to your financial obligations
- Estimating the cost of your proposed treatment
- Outlining payment options available to you
- Assistance with understanding insurance benefits
- Connecting you with benefit plan personnel

Insurance: At each visit, please be prepared to present proof of current insurance, regardless of coverage. If you fail to provide us with your correct insurance information in a timely manner, you will be responsible for payment of services rendered. If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes may result in denial of claims and patient responsibility for payment of the denied claim. You are responsible to verify your insurance benefits and to ensure appropriate insurance referrals are obtained prior to services being rendered. SRM Financial Counselors are available to assist in this matter, however, failure to do so may result in your financial responsibility for services. If a referral is required by your insurance carrier and not obtained, the appointment will be treated as self-pay.

If we are billing your insurance, your deposit for estimated patient responsibility is due for known deductibles, coinsurance, co-payment, and non-covered services or contract excluded services prior to the start of your ART cycle (IVF, FET).

Co-payments: Co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some services you receive may be determined by your insurance plan to be partially covered or not covered. You will be financially responsible for the cost of services that are not paid.

Non-billable Services: Phone consultations, acupuncture and psychological counseling are currently not billable to insurance. You will be responsible for filing claims if these services are covered by your plan.

Telemedicine: Telemedicine (video or telephone) appointments may be billable to your insurance if covered by your benefit plan. If the charge is denied by your insurance the balance will become patient responsibility.

Claims submission: Your insurance benefit is a contract between you and your insurance company. We will submit your claims only if we have determined that you have a benefit for the services rendered. We do not courtesy-bill insurance if we have been advised there's no coverage for the services. Your insurance company may need you to supply certain

information directly in order to process a claim. It is your responsibility to comply with their request(s). **Please be aware that any amounts not covered by your insurance company will be your responsibility.**

Missed and no-show new patient appointments: If you cancel your initial appointment with less than 48-hours' notice twice or no-show twice, you will be notified that a $350 non-refundable deposit will be required to schedule your third new patient visit. This advance payment will be applied to the charges for your appointment. If you no-show or cancel with less than 48-hours' notice for the third scheduled new patient appointment you will forfeit the $350 deposit.

Refunds: In the event you have overpaid your account, the credit will remain on your account to be applied to future services if treatment is ongoing. If treatment has been discontinued, a refund check will be mailed to you after all pending balances have been paid on all accounts. In the event SRM is unable to contact you or the refund check is not cashed and more than three (3) years has elapsed after becoming payable, the balance will be reported to the State of Washington as Unclaimed Property in accordance with RCW 63.29.170.

Storage Fees: You are strongly encouraged to enroll in our auto-payment process for any specimen stored at SRM. We will provide you with the auto payment enrollment form once you have any specimen stored. Storage fees are posted to your account by the 10th of each month. Please understand you will be billed per specimen type (embryos, oocytes, or sperm) per month.

Past due balances: Payment is due in full at the time a billing statement is received. If any invoice remains unpaid for more than sixty (60) days, we may cease performing services for you until you make satisfactory arrangements to pay your bill. If the delinquency continues, we will make written and verbal efforts to notify you of any past due balances on your account. After a balance is 120 days past due, SRM may engage an attorney or collection agency to collect any past due balance. Attorney and/or court fees may be charged to you and collected in accordance with Washington State law. Accounts which are 120 days or more past-due and sent to collections will be assessed a fee based on the table below. This fee will be added to the outstanding balance due.

Outstanding Balance	Fee
$0.01-$500.00	$50
$500.01-$1,000.00	$75
$1,000.01-$1,500.00	$100
$1,500.01-$2,000.00	$125
$2,000.01-$2,500.00	$150
$2,500.01-$3,000.00	$200
$3,000.01-$3,500.00	$225
$3,500.01 and greater	$250

Accepted Payments: SRM accepts Visa, MasterCard, American Express, Discover, cash, wire transfer, money order, cashier's check or financing from our partner lender. Payments may be made over the phone, in any of our offices, or online by visiting our website (www.seattlefertility.com). Please inquire with any of SRM's Financial Counselors for information related to third-party financing.

Returned checks: A fee of $25.00 will be assessed for each returned check.

VIDEO OR AUDIO RECORDINGS

SRM may receive requests for either audio or video recordings during consultations and procedures. SRM has the following policy below regarding these requests.

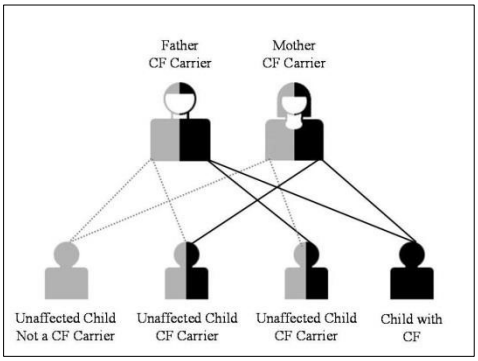
- No hidden recordings of any nature may be used. ○ Audio or video recordings may be undertaken only with the consent of the provider. ○ Audio recordings, if consented, may only be used during a consultation.
- Video recordings, if consented, may only take place after a procedure is completed to review or recap the procedure. This recording will be strictly at the discretion of the provider.
- Any recording made must be with the understanding that this is for personal use and not to be published.
- Permission to record employees, facilities, machinery, results (sonograms, etc.) or fellow patients is prohibited.

PRECONCEPTION GENETIC AND IMMUNITY TESTING

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Medical Genetics (ACMG) recommends testing for certain genetic diseases based on ethnicity, family history, or other known risk factors and testing for certain contagious diseases that can be harmful to a fetus, prior to pregnancy.

Genetic Disorders

Every normal person can carry genes that may give rise to a child with a genetic disorder if the child inherits a copy of the abnormal gene from both parents. These are called recessive genes and their prevalence varies among ethnic groups. When both parents are carriers of the same recessive disease, there is a 1 in 4 (25%) chance that the child will inherit the trait from both parents and have the disease, a 1 in 2 (50%) chance that the child will inherit the trait from only one parent and be a carrier, like the parents, or a 1 in 4 (25%) chance that the child will not inherit the trait from either parent and will not be a carrier or have the disease.



Carrier status for a recessive disease is passed silently from generation to generation. Carriers can only be identified by a specific genetic test.

There are a number of specific genetic disorders that could be passed on to a child. A parent can carry a gene for a disorder but not have the disease themselves; therefore they are completely healthy. If an individual carries a genetic defect, the resulting child has a certain risk of actually having the disease or of being a genetic carrier themselves. This risk to the child is high if both parents carry the same genetic defect. Most of these illnesses are substantial, generally associated with a shorter life span, and have serious ongoing medical problems. A good example of one of these diseases is cystic fibrosis. An individual with cystic fibrosis can have breathing and gastrointestinal problems throughout their life.

The risk for these genetic diseases is based on a person's ethnicity. For instance, Caucasians are more at risk for cystic fibrosis while Asians are more at risk for a serious anemia called thalassemia. People of Jewish ancestry are more at risk for a series of specific metabolic disorders. For individuals of Asian or African ethnicity a complete blood count (CBC) is recommended in addition to the genetic tests.

Several professional organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American College of Medical Genetics (ACMG) have recommended routine screening of the pre-pregnant population for the most common disorders.

Your provider at SRM recommends pre-pregnant genetic testing. The results are usually available in 12-14 days.

Contagious Infectious Diseases

There are certain contagious diseases that can be harmful to a fetus if a woman is exposed during pregnancy. These diseases can be avoided or be less harmful if the mother receives an immunization prior to pregnancy. It is recommended that all women wanting to become pregnant have their immunity to *rubella* and *varicella* tested. If she is found to be susceptible to either of these diseases, it is recommended that she have an immunization prior to pregnancy. It may be also recommended to wait 30 days after receiving an immunization before attempting conception.

Women are also encouraged to receive a single Tdap (*tetanus, diphtheria,* and *acellular pertussis*) booster once as an adult prior to pregnancy. Td vaccine (*tetanus* and *diphtheria*) is recommended for women who are already immune to pertussis and have had 10 or more years elapse since a previous Td booster.

In addition, an *influenza* (flu) vaccine is recommended prior to pregnancy.

Zika Virus

There is growing evidence of a connection between exposure to Zika during pregnancy and microcephaly in resulting offspring, although it is not known whether infection with the Zika virus causes microcephaly. Microcephaly is a condition in which a baby is born with a much smaller head than normal, because the brain has not developed properly during pregnancy. The baby may suffer from a number of physical and cognitive problems, ranging from mild to severe, including a decreased ability to learn and function.

Zika virus may also cause Guillain Barre Syndrome in infected individuals. Guillain Barre Syndrome can start as tingling in the extremities and progress to muscle weakness that in severe cases may result in paralysis.

Understanding of the Zika virus and its effect on infected pregnant women and their babies is still evolving. The Centers for Disease Control (CDC) is the primary resource for information and has the most current information including a list of countries affected. http://www.cdc.gov/zika/about/index.html

Based upon the information available regarding the risk to the unborn child and to patients, the physicians at SRM strongly advise you and any Spouse/Partner NOT to travel to countries with active Zika transmission while attempting pregnancy.

If you or your Spouse/Partner have recently traveled to, or have had sex without a condom with a man infected with Zika, and you choose to attempt pregnancy, **SRM** will require that you wait to attempt pregnancy according to the timeframes currently suggested by the CDC and ASRM.

Patient Rights and Responsibilities

As a patient, you have the right to:

- Be treated with respect, consideration, and dignity.
- Treatment without regard to sex, cultural, economic, educational, or religious background or the source of payment for your care.
- Be provided appropriate privacy at check-in and in treatment areas. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Privacy in regard to all communications and records pertaining to your care. Your written permission shall be obtained before your medical records are made available to anyone not concerned with your care.
- Interpretation services.
- Knowledge of the name of the provider who has primary responsibility for coordinating your care and the names and professional relationships of other providers from whom you may receive care.
- Be provided with information about your diagnosis, evaluation, treatment, and prognosis to the degree that it is known. This information shall include a description of the treatment or procedure, alternate course of treatment or non-treatment, and the medically significant risks involved. This information will be provided in terms you can understand. You will be given the opportunity to participate in decisions involving your health care and to give informed consent or to refuse treatment, except when such participation is contradictory for medical reasons. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by you or to a legally authorized person.
- Reasonable responses to any reasonable request you make for services.
- Be informed by your provider or designee of your continuing health care requirements.
- Be informed of unanticipated outcomes.
- Reasonable continuity of care and to know in advance the time and location of appointments as well as the provider administering the care.
- Be advised if the provider proposes to engage in or perform human experimentation affecting your care or treatment. The patient has the right to refuse to participate in such research projects.
- Examine and receive an explanation of your bill regardless of source of payment.
- Have all patient rights explained to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
- Family input in care decisions, in compliance with existing legal directives of the patient or existing court-issued legal orders.

- Complain about your care and treatment without fear of retribution or denial of care.
- Resolving problems with care decisions and/or complaints in a timely manner.
- You have the right to change providers if other qualified providers are available.
- Protection from abuse or neglect.
- Access to protective services.
- Express any grievances or suggestions verbally or in writing to Seattle Reproductive Medicine Management and/or the Accreditation Association for Ambulatory Healthcare at 847-853-6060 or Washington Department of Health Complaint Hotline at 800-633-6828.

Please visit http://www.seattlefertility.com to learn about our practice, philosophy, and team members.

As a patient, you have the responsibility to:

- Communicate with your provider. Communication is essential to a successful provider-patient relationship.
- Provide complete and accurate information to the best of your ability about your health. This shall include past illnesses, hospitalizations, family history of illness, any medications taken including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the agreed-upon treatment plan prescribed by your provider and participate in your care. Compliance with provider instructions is often essential to public and individual safety. As a patient, you also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when you would like to reconsider the treatment plan.
- Request information or clarification about your health status or treatment when you do not fully understand what has been described.
- Accept personal financial responsibility for any charges not covered by insurance.
- Behave respectfully towards all health care professionals and staff, as well as other patients and visitors.
- Provide a responsible adult to transport you home and to remain with you as directed by your provider after receiving any anesthetic and/or sedative medications.

ACKNOWLEDGEMENT FORM

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Notice of Privacy Practices*. This signature is required for Seattle Reproductive Medicine to bill your insurance.

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Financial Policy.*

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Video & Audio Recording Policy*.

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Preconception Genetic and Immunity Testing*. Preconception genetic and immunity testing is recommended but not required prior to fertility therapy. The choice to proceed with some or all of the recommended testing is yours. Your signature acknowledges that you realize genetic testing and immunity screening has been recommended to you prior to initiating fertility therapy.

I acknowledge that I have read and understood my *Patient Rights and Responsibilities.*

I acknowledge SRM's 24-hour Emergency Paging 206-301-5000 for after hours and emergency care.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO SPOUSE/SIGNIFICANT OTHER

This authorization grants permission to my Spouse / Significant Other / Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and fertility treatment plans; and have access to my financial health information.

Patient Name (please print):

_____

Date of Birth:

_____

Spouse / Significant Other / Other:

_____

Relationship to Patient:

_____

Phone:

_____

I hereby authorize Seattle Reproductive Medicine to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named above, the released information may no longer be protected by federal privacy regulations.

I understand that this authorization will be effective for the lifetime of the patient unless revoked. I understand that I may revoke this authorization at any time by notifying Seattle Reproductive Medicine in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Seattle Reproductive Medicine prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

(Form must be completed before signing or will not be valid)

_____ _____

Patient Signature Date

Disposition: File this Acknowledgement Form in the patient's medical record

* * YOU MAY REFUSE TO SIGN THIS AUTHORIZATION * *

ELECTRONIC COMMUNICATION CONSENT

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are nonemergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient healthcare provider/team relationship; rather it can support and strengthen an already established relationship.
The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo and Hotmail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice, however, the recipients' email addresses will be hidden.

Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within 2 business days (Monday – Friday, non-holidays). *If you do not receive a response from the practice within 2 business days, please contact the practice by phone.*
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team. I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with a representative of SRM and have had all my questions answered. In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via non-secure email services. I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent. I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

Patient Authorized Email Address (please print legibly)

Patient Signature _____Print Name _____ Date _____