REGISTRATION FORM

REPROTECH LIMITED

RTL Account #_____
(RTL staff assigned)

Patient Information	Partner Information (If Applicable)
Full Name	Full Name
Email	Email
(Please note that email address will be used for billing and correspondence)	(Please note that email address will be used for billing and correspondence)
Date of Birth	Date of Birth
Gender	Gender
Cell Phone #	Cell Phone #
Home/Alt Phone #	Home/Alt Phone #
SS #	SS #
Billing Street Address	Billing Street Address
City State Zip	City State Zip

Tissue Type ❑ Embryo ❑ Oocyte ❑ Semen ❑ Ovarian Tissue ❑ Testicular Tissue
❑ Donor Oocytes: ID#_____ ❑ Donor Semen: ID#_____ ❑ Donor Embryo: ID#_____

Reason For Banking _____ (i.e. Cancer Treatment, IVF Back-up, Vasectomy, Hormone Therapy, etc.)

Non-Fertility Referring Doctor (if applicable, i.e. Oncologist, Urologist) Name_____

Address _____
Street City State Zip

Have you or your partner ever **had a positive test result** for HIV, Hepatitis B, Hepatitis C, HTLV I & II, Syphilis, Chlamydia, Gonorrhea, Zika Virus, West Nile Virus, COVID-19 or other communicable disease? **Check one: ❑ No ❑ Yes,** please specify:_____

Have you or your partner ever **cared for, lived with, or otherwise had close contact with** individuals diagnosed with COVID-19 infection? Check one: ❑ **No** ❑ **Yes,** please explain:_____Dates:_____

Have you or your partner ever **lived or traveled** where the CDC has issued a **travel alert or warning** due to risk of disease transmission for Zika Virus, Ebola or other disease? Check one: ❑ **No** ❑ **Yes:** Where did you travel?_____ Dates:_____

Embryo Clients Only
Were donor eggs or donor semen used to create your embryos? Check one: ❑ **Yes** ❑ **No** If yes, please specify_____
Was a gestational carrier used for your IVF procedure? Check one: ❑ **Yes** ❑ **No**

Payment Options: Please indicate your choice of **billing interval** for storage fees. Storage fees are non-refundable. Storage and shipping fees must be prepaid. ❑ Quarterly ❑ 1 year ❑ Multi-year _____ (choose 2, 3, 5 or 10 years, visit www.reprotech.com for pricing).
Progyny ID # _____ (Only applies if you have Progyny coverage) **Carrot Fertility Code:** _____ (Carrot Fertility members only)

Credit Card Authorization: Your signature here authorizes ReproTech, Ltd. to charge your credit card for shipping and storage fees.
❑ Check here if you are only authorizing RTL to use your credit card for the first annual or multi-year storage period and the shipping fees. Please note that quarterly storage fees are automatically billed and are not eligible for a one-time authorization.

Signature:_____ Date _____ Account Number_____

Name on Card _____ Expiration Date _____

****NOTE THAT CREDIT CARD PAYMENT IS REQUIRED FOR ALL INTERNATIONAL PATIENTS.**

Referring Fertility Physician/Clinic (where specimens are currently located or will be created)

Name_____Telephone_____

SIGNATURE(S) BELOW ARE REQUIRED Your signature(s) below acknowledges acceptance of our privacy policy (www.rtlhipaa.com) and indicates that all information provided on this document is true and accurate. In addition, you agree to keep ReproTech updated with your current address and contact information.

Signature of Patient (or Parent/Guardian if minor) _____ Date_____

Signature of Partner (If Applicable) _____ Date_____

If you would like to request information about your account be released to someone other than yourself, please contact ReproTech or go to www.rtlmedicalinforelease.com to download the form and name another individual to whom we may release medical information.