PLEASE COMPLETE THIS FORM AND EMAIL TO THE BUSINESS OFFICE OR YOUR FINANCIAL COUNSELOR IN YOUR PATIENT PORTAL

Reproductive Science Center
Experience Never Mattered More

Recurring Credit Card Authorization for Storage of Cryopreserved Specimen(s)

The undersigned authorizes Reproductive Science Center (RSC) to debit my Credit Card for any current cryo storage fees due on my account and for future payments due on my monthly Cryo-preservation Storage Fees.

The following conditions apply to the recurring payments program:

You may discontinue the recurring credit card payment plan by providing RSC with a signed disposition form indicating your intention of discontinuing cryo-preservation storage. Please be aware that the RSC financial policy requires recurring Credit Card Payments for all Cryo-preservation Storage.

According to the American Society of Reproductive Medicine (ASRM), a Fertility Center is not ethically required to store cryo-preserved biomaterials indefinitely and may dispose of such biomaterials after a passage of time that reasonable suggests that the owners have abandoned them. ASRM indicates that cryo-preserved biomaterials may be considered abandoned when a reasonable period of time has passed without contact from the owner, diligent efforts have been made to contact the owner at the last known address and no written instructions from the owner exists concerning disposition.

Please complete the authorization information below:

I _____ (please print name) authorize *Reproductive Science Center* to charge my credit card $55.00 on the 20th day of each month for payment of my Cryo-preservation Storage Fees. Please note, you will owe $55 per specimen type (Sperm, Oocytes, Embryos) if stored. The monthly storage fees will increase to $130/mo at 5+ years of storage.

Patient Name (Specimen stored under) : _____DOB: _____ Medical Record #_____

Address_____ _____Phone# _____

City, State, Zip _____ Email _____

SIGNATURE_____DATE _____

I have the following specimen stored: (check all that apply) Embryos ☐ Oocytes ☐ Sperm ☐

Cryopreservation Storage Payment Authorization
For Office Use Only

CREDIT CARD INFORMATION:

Visa MasterCard Amex Discover
Cardholder Name: _____
ACCN: _____
EXP:_____
CVV (3 digit number on back of card) _____

I authorize the above named business to charge the credit card(s) indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing and provide a completed disposition form to the practice, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.