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. If you indicate your interest in participating in the Attain IVF Program, we will provide relevant information concerning your medical condition to IntegraMed America's Attain Fertility Division for determination of your qualifications for this financing program.

*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: the management services of Integramed America, Inc. and 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. Please direct any questions you may have to our Finance department.

- Patient is responsible for payment of known deductibles, co-insurance, co-payment, and non-covered/contract exclusion services at the time of service for all services. For ART cycles (IVF, DEP, FET), patient responsibility payment is due in full prior to the start of the ART cycle.

- Balances that are unknown at the time of service will be billed to the patient. Patient is responsible for the prompt payment of these balances. Balances not paid within 30 days will be subject to finance charges.

- A fee of $25.00 will be assessed for each returned check.

- Patient is responsible for all fees associated with or incurred due to non-payment of account. These fees include, but are not limited to collection agency, legal and court fees.

- Patient is responsible to verify insurance benefits and to ensure appropriate insurance authorizations, precertifications and referrals are obtained prior to services being rendered. SRM Financial Counselors are available to assist in this matter, however, failure to do so will result in the patient's financial responsibility for non-authorized services. If a referral is required by the insurance carrier and not obtained, the appointment will be rescheduled.

FINANCIAL COUNSELORS ARE AVAILABLE TO PROVIDE ADDITIONAL INFORMATION

VIDEO OR AUDIO RECORDINGS

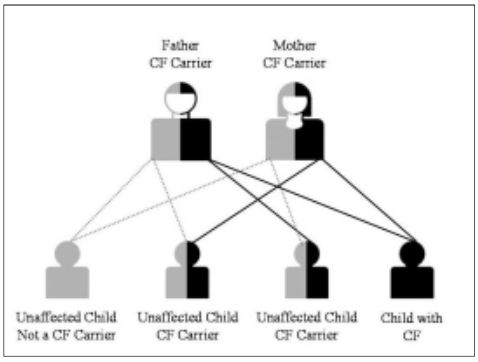
SRM may receive requests for either audio or video recordings during consultations and procedures. SRM has the following policy below regarding these requests.

- 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.

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 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 non-emergent, 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 _____