

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes RBA's privacy practices, as well as the privacy practices of:

- Any RBA health care professional and all employees, staff and personnel and volunteers of RBA; and
- Southeastern Fertility Institute; Surgical Associates; and Southeastern Endocrine Labs (together the "RBA Entities", which operate as an organized health care arrangement together with RBA and present this document as a joint notice of privacy practices.

OUR PLEDGE TO YOU

We understand that information about you and your health is personal. We are required by law to make sure your health information is protected and to give you this Notice which explains the ways in which we may use and disclose medical information about you. The Notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following describes different ways we may use and disclose your health information for which we do not need your written permission (authorization). The examples listed below are not exhaustive.

- **For Treatment:** We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your health information when consulting with another provider about your course of treatment.
- **For Payment:** We can use and disclose your health information to bill and receive reimbursement for your care. For example, we may need to give your health plan information about a treatment you are going to receive to obtain prior approval.
- **For Health Care Operations:** We may use and disclose your health information for our health care operations. For example, we may need to use your information when scheduling appointments and other pre-treatment activities.
- **Uses or Disclosures Required by Law:** We may use or disclose your health information to the extent such use or disclosure is required by law.
- **Health Agency Oversight Activities:** We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- **Law Enforcement:** We may disclose your health information for law enforcement purposes.
- **To Avert a Serious Threat to Health or Safety:** We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- **Public Health Risks:** We may disclose health information about you for public health activities.
- **Workers' Compensation:** We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- **To Respond to Lawsuits and Legal Actions:** We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- **Business Associates:** We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- **Individuals Involved in Your Care:** We may disclose health information to a family member, friend, or any other persons identified by you if either: (a) you do not object to the disclosure, or (b) in certain emergency situations.
- **Marketing and Sale of Health Information:** We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may revoke this authorization at any time, except to the extent that RBA has already relied on your authorization. If you decide to revoke your authorization, please send a completed *Authorization Revocation* form to the address below.

YOUR RIGHTS

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**: You have the right to inspect and obtain a copy of your health information. We may charge a reasonable, cost-based fee.
- **Right to an Accounting of Disclosures**: You have the right to request an “accounting of disclosures.” We will provide you one accounting of disclosures each year free of charge but may charge a reasonable, cost-based fee if you ask for another accounting within twelve (12) months.
- **Right to Amend**: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment. We may deny your request in certain circumstances.
- **Right to Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request.
- **Right to Request Confidential Communications**: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- **Right to be Notified of a Breach**: You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- **Right to a Paper Copy of This Notice**: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice, and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future, as of the effective date of the revised Notice. We will post a copy of the current Notice on our Internet site at www.rbaivf.com.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with RBA or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer, Donna Ayers, at the address and telephone number listed below. **You will not be penalized for filing a complaint.**

FURTHER INFORMATION

For further information, you may contact:

**Donna Ayers, Privacy Officer at Reproductive Biology Associates
1100 Johnson Ferry Road NE, Suite 200
Atlanta, Georgia 30342
(404) 459 – 3473**



TERMS AND CONDITIONS OF SERVICE

I understand that Reproductive Biology Associates, LLC, is affiliated with Inception Fertility Holdings, LLC, a management company responsible for multiple fertility centers across the United States. I understand that the providers Andrew A. Toledo, M.D., Daniel B. Shapiro, M.D., Scott M. Slayden, M.D., Robert J. Straub, M.D., Jessica R. Rubin, M.D., Monica W. Best, M.D., and Michael A. Witt, M.D. from whom I am seeking treatment, is therefore affiliated with Inception Fertility Holdings, LLC. I understand that the provider from whom I am seeking treatment is affiliated with Inception Fertility Holdings, LLC. These Terms and Conditions of Service (this “**Agreement**”) apply to all physicians, nurses, embryologists and other practitioners, physician practices, fertility laboratories, tissue storage repositories and management services organizations owned, directly or indirectly,

or otherwise affiliated with, Inception Fertility Holdings, LLC (each, a “**Provider**”) ¹. Both the patient and the patient’s partner, as applicable, are parties to this Agreement and are referred to as “I”. This Agreement lays out the legal terms and conditions that apply to all treatment(s), procedure(s) or service(s) (referred to in this document as “**Services**”) I will receive from any Provider.

Representations of Patient and Partner

- I understand that this Agreement applies to any and all Services I receive from any Provider, and that without my acceptance of this Agreement such Provider would not provide the Services to me.
- I am seeking Services on a voluntary basis and not on an emergency basis.
- I have a choice of providers from whom I could seek Services.
- I understand that there is a separate informed consent process for clinical service(s) and/or procedure(s), but that this Agreement will apply to all such Services.
- I acknowledge that this Agreement is being provided to me (us) as part of the patient intake process at Provider’s practice where I will receive Services, and that I enter into this Agreement on a voluntary basis.
- I acknowledge that Provider has not given me legal advice, and I am not relying on Provider to give any legal advice.
- I acknowledge that it is my/our responsibility to take any further legal action, if any, required to establish parentage of any offspring resulting from the Services under applicable law.

Liquidated Damages for Loss, Damage or Destruction of Tissue

I acknowledge and agree that in the event of loss, damage or destruction of any human tissue collected, stored or used in connection with any Service (collectively, “**Tissue**”) at any time, my actual damages would be impracticable to determine. I therefore agree that in the event of loss, damage, misuse, improper testing, freezing, thawing, delivery or destruction of Tissue for any reason whatsoever, including but not limited to equipment failure or malfunction, failure of utilities, cession of services, failure by another laboratory provider, or acts of God, my Partner and I collectively shall be entitled to liquidated damages in the amount equal to the actual cost of the Services performed by Provider as of the date such loss, damage or destruction occurred, specifically excluding costs of medications. I hereby agree to hold harmless Provider and its shareholders, directors, officers, employees, agents, representatives (“**Representatives**”) from all actions, causes of action, obligations, costs, expenses, attorney’s fees, damages or losses (“**Claims**”) related to Tissue, except for the liquidated damages set forth in this paragraph.

No Punitive or Consequential Damages

TO THE FULLEST EXTENT PERMITTED BY LAW, I WAIVE ANY RIGHT TO, OR CLAIM FOR, ANY PUNITIVE, EXEMPLARY, INCIDENTAL, INDIRECT, SPECIAL OR CONSEQUENTIAL DAMAGES (INCLUDING, WITHOUT LIMITATION, DAMAGES FOR EMOTIONAL DISTRESS) WHICH I MAY HAVE AGAINST PROVIDER, ITS REPRESENTATIVES (AS DEFINED HEREIN) AND AFFILIATES ARISING OUT OF ANY CAUSE OF ACTION WHATSOEVER (WHETHER SUCH CAUSE BE BASED IN CONTRACT, NEGLIGENCE, STRICT LIABILITY, OTHER TORT OR OTHERWISE) AND AGREE THAT IN THE EVENT OF A DISPUTE, RECOVERY SHALL BE LIMITED TO ACTUAL DAMAGES. IF A COMPLETE WAIVER OF PUNITIVE, EXEMPLARY, INCIDENTAL, INDIRECT, SPECIAL OR CONSEQUENTIAL DAMAGES IS NOT PERMITTED BY LAW, I AGREE THAT ANY SUCH DAMAGES WILL BE CAPPED AT THE LIMIT SET BY STATE LAW WHERE THE SERVICES WERE PERFORMED THAT GAVE RISE TO THE CAUSE OF ACTION. IF ANY OTHER TERM OF THIS AGREEMENT IS FOUND OR DETERMINED TO BE UNCONSCIONABLE OR UNENFORCEABLE FOR ANY REASON, THE PROVISIONS SHALL CONTINUE IN FULL FORCE AND EFFECT, INCLUDING, WITHOUT LIMITATION, THE WAIVER OF ANY RIGHT TO CLAIM ANY CONSEQUENTIAL DAMAGES.

Agreement to Arbitrate All Claims

Any and all disputes arising from or relating directly or indirectly to 1) the Services, including but not limited to any claims that Services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, or 2) this Agreement, including but not limited to any dispute relating to the interpretation, applicability, enforceability, or formation of this Agreement (including the enforceability of this arbitration clause), shall be settled by binding arbitration in Houston, Texas, in accordance with the then-current rules of the American Arbitration Association, and judgement upon the award entered by the arbitrators may be entered in any Court having jurisdiction hereof. This agreement to arbitrate will apply to all Claims that I may assert against any Provider and any of Provider’s Representatives, affiliates, consultants, service providers, or other persons or entities providing Services and any of their employees. All parties to this Agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Each party will be responsible for its own arbitration costs and attorneys’ fees. Said arbitration shall be conducted in the English language and any award rendered shall be in United States dollars.

No Class Action Claims

I WAIVE ANY RIGHT TO ASSERT ANY CLAIMS AGAINST PROVIDER ITS REPRESENTATIVES (AS DEFINED HEREIN) AND AFFILIATES AS A REPRESENTATIVE OR MEMBER IN ANY CLASS OR REPRESENTATIVE ACTION, EXCEPT WHERE SUCH WAIVER IS PROHIBITED BY LAW OR DEEMED BY A COURT OF LAW TO BE AGAINST PUBLIC POLICY. TO THE EXTENT I AM PERMITTED BY LAW OR COURT OF LAW TO PROCEED WITH A CLASS OR REPRESENTATIVE ACTION AGAINST PROVIDER, ITS REPRESENTATIVES OR AFFILIATES, I AGREE THAT: (I) IF I PREVAIL, I SHALL NOT BE ENTITLED TO RECOVER ATTORNEYS’ FEES OR COSTS ASSOCIATED WITH PURSUING THE CLASS OR REPRESENTATIVE ACTION (NOT WITHSTANDING ANY OTHER PROVISION IN THIS AGREEMENT); AND (II) IF I INITIATE OR PARTICIPATE AS A MEMBER OF THE CLASS I WILL NOT SUBMIT A CLAIM OR OTHERWISE PARTICIPATE IN ANY RECOVERY SECURED THROUGH THE CLASS OR REPRESENTATIVE ACTION.

Agreement Enforced to Extent Permitted by Law

If any clause or provision of this Agreement is deemed invalid or unenforceable, the remainder of this Agreement shall remain in full force and effect.

Acknowledgement and Signature

I acknowledge that I have read this Agreement and fully understand the terms outlined therein, and that I understand the terms contained in this Agreement. I also understand I am free to seek legal advice prior to executing this Agreement. I have had an opportunity to ask questions, and now hereby consent to this Agreement for all Services I receive or will receive in the future from Provider.

NOTICE:

BY SIGNING THESE TERMS AND CONDITIONS YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

<p>Patient</p> <p>_____</p> <p>Name:</p> <p>Date signed:</p>	<p>Partner</p> <p>_____</p> <p>Name:</p> <p>Date signed:</p>
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