The ARC Refund Guarantee Program Application™

FOR PATIENTS USING THEIR *OWN* EGGS

Shown below are a few of the key factors that are considered for participation in the ARC Refund Program. If you have any of these factors, you will NOT qualify for the Progressive Refund Program; however, you can still participate in the Classic Three-cycle Refund Program, which accepts all patients, unless you are doing PGD (Preimplantation Genetic Diagnosis) or PGS (Preimplanation Genetic Screening). The refund program is designed for patients doing either traditional IVF treatment or donor egg cycles, and cannot be used with frozen donor eggs or embryo adoption.

- **38 years or older (Treatment must be finished by 38th birthday)**
- **Prior failed IVF cycle or miscarriage**
- **Body Mass Index of 30 or higher**
- **Ovarian Cystectomy or Endometrioma**
- **FSH and Estradiol levels over normal limits**
- **Untreated Hydrosalpinx**
- **Insufficient Antral Follicle Count**
- **Abnormal uterus**
- **PGD/PGS (Preimplantation Genetic Diagnosis/Screening)**

(PGD/PGS cannot be done for either Progressive or Classic)

FOR PATIENTS USING *DONOR* EGGS

Shown below are a few of the key factors that are considered for participation in the ARC Refund Program. If you have any of these factors, you will NOT qualify for the Refund Program. The refund program cannot be used with frozen donor eggs or embryo adoption.

- **Body Mass Index of 30 or higher**
- **Untreated Hydrosalpinx**
- **Donor must be under age 30 & have a normal ovarian reserve**
- **Prior failed donor IVF cycle or miscarriage with donor eggs**
- **Abnormal uterus**
- **PGD/PGS (Preimplantation Genetic Diagnosis/Screening)**

You will be provided with preliminary pricing within 5 business days. If you are interested in pursuing the Refund Guarantee after you have reviewed the preliminary pricing, then your doctor will need to review and confirm the information that you have provided within this Program Application. All required lab results (FSH, Estradiol, semen analysis, and uterine evaluation) must be completed within 90 days of starting treatment.

ARC HAS A $75.00 NON-REFUNDABLE PROCESSING FEE FOR THE PRICING OF YOUR APPLICATION. YOU MAY PROVIDE CREDIT CARD INFORMATION BELOW, OR MAIL, WITH YOUR CHECK PAYABLE TO ARC TO:
20195 Stevens Creek Boulevard, Suite 100, Cupertino, CA 95014

Credit Card Number_____ **Exp**_____

CVV Number _____ **Cardholder Name** _____

Cardholder Address _____

(MasterCard, VISA, AmEx, Discover cards accepted)

To process your application today, fax it to (877) 655-2727 or mail all pages to ARC with payment information as referenced above.

An ARC Patient Service Specialist will contact you within five business days.

ARC PRIVATE & CONFIDENTIAL

PATIENT NAME: _____

I am interested in the following packages:

- ☐ **The ARC Refund Guarantee™ (*Complete The ARC Program Application & Fax to 877-655-2727)***
  - **One Cycle *Plus* IVF Option™**
  - **Two Cycle *Plus* IVF Option™**
  - **Three Cycle *Plus* IVF Option™**
  - **Donor Cycle *Plus* IVF Option™**

PLEASE NOTE THAT YOU DO NOT NEED TO COMPLETE THE PROGRAM APPLICATION IF YOU ARE INTERESTED IN PRICING FOR TREATMENT PACKAGES* WITHOUT *THE REFUND GUARANTEE. PLEASE CALL THE ARC PROGRAM OFFICE AT (888) 990-2727 FOR REGULAR PRICING.

How do I plan to cover my treatment costs?

- ☐ **Personal Check**
- ☐ **Credit Card**
- ☐ **The ARC Financing Program** ***[Please call ARC at (888) 990-2727 to obtain instructions on how to apply with our lending partners]***

I would like help with financing my treatment costs. If so, ↓

If you are interested in Patient Financing, please call ARC at (888) 990-2727 to complete a loan application over the telephone with one of our Patient Services Specialists. Please note that this ARC Program Application is for pricing on the Refund Guarantee Program ONLY, and is not an application for financing or to purchase a package.

Patient Contact Information

Date Form Completed: _____
Month Day Year

Name: _____
First Middle Last

Mailing Address: _____

City/State/Zip Code: _____

Date of Birth: _____
Month Day Year

Home Telephone: (_____)_____ **Home Fax:** (_____)_____

Cell Phone: (_____)_____ **Personal Email:**_____

Occupation: _____

Work Telephone: (_____)_____ **Work Fax:** (_____)_____

- **ARC Physician Selected:*** _____
- **Practice Name:*** _____

*** You must be an established patient at an ARC practice in order to have your application verified by a physician. This means that you must have already been evaluated by an ARC network physician.**

Partner Contact Information

Name: _____
First Middle Last

Date of Birth: _____
Month Day Year

Cell Phone: (_____)_____ **Personal Email:**_____

Work Telephone: (_____)_____ **Work Fax:** (_____)_____

Patient's Name

Patient's Clinical Information

Please respond to all of the following to the best of your knowledge. These questions pertain to the condition of infertility and the information is kept confidential. If you do not know the answer, please leave it blank.

HEIGHT _____ WEIGHT _____

		YES	NO
1.	Do you have irregular cycles? "Irregular" means fewer than 22 days or more than 35 days	❑	❑
2.	Have your cycles been shorter in past year? "Shorter" means shorter by more than 2 days	❑	❑
3.	Do you respond poorly to clomiphene (Clomid)?	❑	❑
4.	Have you ever responded poorly to gonadotropins with IUI or IVF? (injectible stimulation medications)	❑	❑
5.	Have you been diagnosed with premature menopause?	❑	❑
6.	Have you had Cycle Day 3 Follicle Stimulating Hormone (FSH) level? If "YES", what is the highest level you have had? _____	❑	❑
7.	Have you had Cycle Day 3 estradiol level? If "YES", what is the highest estradiol level you have had? _____	❑	❑
8.	Do you currently smoke cigarettes? If "YES", how many cigarettes do you smoke per day? _____ If "NO" and previously smoked, date you quit, and # of cigarettes smoked per day _____	❑	❑
9.	Do you drink alcoholic beverages? If "YES", how many drinks do you have per week?_____	❑	❑
10.	Do you have drinks with caffeine? If "YES", how many caffeine drinks do you have per day? _____	❑	❑

Patient's Name

Patient's Clinical Information

YES **NO**

11. Do you use recreational drugs? ❑ ❑
If "YES", please list them below.

Drug Name	Amount	Duration of Use

12. Do you take prescription or "over-the-counter" (OTC) drugs? ❑ ❑
If "YES" please list below.

Drug Name	Dose	Duration of Use	Reason for Use

13. Do you have only one ovary? ❑ ❑

14. How long have you and your partner had intercourse without either of you using birth control? Please put "N/A" if you have had your tubes tied, or husband has a vasectomy. Years_____ Months_____

15. Have you had any prior live births? (without "ART") ❑ ❑

16. Have you had a birth involving assisted reproductive technology? ❑ ❑
Assisted reproductive technologies ("ART") include IVF, GIFT & ZIFT

17. Have you ever had an elective termination of a pregnancy (abortion)? ❑ ❑

18. Have you ever had a spontaneous abortion (pregnancy loss or miscarriage, excluding ectopic pregnancy)? ❑ ❑
If "YES", please indicate the number _____

19. Do you know the cause of these spontaneous abortions (miscarriages)? ❑ ❑
If "YES", please check only one of the following choices:
Untreated ❑ Treated ❑ with improvement Treated ❑ with total resolution

20. Have you ever had a prior premature delivery? ❑ ❑
"Premature" means less than 34 weeks.

Patient's Name

Patient's Clinical Information

		YES	NO
21.	Have you ever had an ectopic pregnancy (tubal pregnancy)?	❑	❑
	If "YES" has the tube in which the ectopic pregnancy occurred been removed?	❑	❑
22.	a. Do you currently have blocked tubes?	❑	❑
	b. Do you currently have hydrosalpinges (fluid in tubes)?	❑	❑
	c. If you have hydrosalpinges, will they be repaired before IVF?	❑	❑
23.	Have you had a blood test indicating an abnormal chlamydia antibody titer? "Abnormal" means a test result of greater than 64.	❑	❑
24.	Do you have a history of endometriosis?	❑	❑
24a.	Do you have a history of endometrioma?	❑	❑
25.	Do you have a congenital uterine anomaly?	❑	❑
	If "YES", please indicate: ❑ minor ❑ major ❑ unknown ❑ type_____		
26.	Do you have an abnormality of the uterine cavity?	❑	❑
	If "YES", please indicate: ❑ minor ❑ major ❑ unknown ❑ type_____		
27.	Do you have any uterine fibroids (myomas) but with normal uterine cavity?	❑	❑
	If "YES", please indicate the number and type_____		
28.	Do you have a moderate to severe abnormality of the uterine cavity?	❑	❑
29.	Do you have a congenitally abnormal cervix or had cervical conization?	❑	❑
30.	Have you had any prior IVF, GIFT or ZIFT cycles?	❑	❑
	If "YES", please indicate the total number of cycles_____ (cycles used for this pregnancy attempt only – do not include frozen cycles)		
	Did the prior cycle(s) result in a live birth?	❑	❑
	If yes, how many of your cycles resulted in a live birth? _____		
	Have you ever had a failed donor egg cycle?	❑	❑
	**Are you planning to use donor oocytes (eggs)? (Donor over age 29 is a disqualifying factor)	❑	❑

Partner's Name

Partner's Clinical Information

Please respond to all of the following to the best of your knowledge. These questions pertain to the condition of infertility and the information is kept confidential. If you do not know the answer, please leave it blank

	YES	NO
Using donor sperm (if so, skip questions 31 thru 34)	❑	❑
Needs ICSI	❑	❑

31. Do you currently smoke cigarettes? ❑ ❑
If "YES", how many cigarettes do you smoke per day? _____

32. Do you drink alcoholic beverages? ❑ ❑
If "YES", how many drinks do you have per week?_____

33. Do you use recreational, prescription or "over-the-counter" drugs? ❑ ❑
If "YES", please list them below.

Drug Name	Dose	Duration of Use	Reason for Use

34. Are you doing TESA/MESA with your IVF cycle? ❑ ❑
(Testicular Sperm Aspiration)
If TESA/MESA has already been done, how many vials of sperm do you have?_____

ADDITIONAL INFORMATION

35. Is PGD or PGS being performed on your embryos? ❑ ❑
(Preimplantation Genetic Diagnosis or Screening)

36. Has the female patient had an Antral Follicle Count done? ❑ ❑
If so, do you know the number of follicles? _____

37. Has the female patient had an AMH level done? (Anti-Mullerian Hormone) ❑ ❑
If so, do you know the number of follicles? _____

Patient's Name & Spouse/Partner Name

PATIENT AND SPOUSE / PARTNER RESPONSIBILITY STATEMENT

I hereby state and certify that, to the best of my knowledge, the responses in this Application are accurate and represent my medical and other history and conditions. I hereby authorize Advanced Reproductive Care, Inc.® ("ARC") to utilize this information in order to process this Application for participation in The ARC Fertility Program®. I understand that ARC will use the information provided in this Application to develop individual prices for me and my Spouse or Partner to consider in the decision whether or not to participate in The ARC Fertility Program®, and in the choice to purchase one of The ARC Treatment Packages™.

I understand that I will be receiving from ARC a Patient Participation Agreement ("PPA") in which my Spouse/Partner will indicate the Treatment Package chosen for purchase, its purchase price and all provisions, terms and conditions of the purchase. Signing the Patient Participation Agreement will represent my acknowledgment and commitment to pay ARC directly for the purchase of my chosen Treatment Package. I understand that ARC has made arrangements and will be responsible for paying my physician for services provided to me as part of my chosen Treatment Package. I will expect to pay ARC by cash, check or credit card, or by using The ARC Affordable Payment Plan™, or by using another method of financing for payment in full. I understand that any services that may be provided by my physician that are not included in The ARC Treatment Packages™ will require that I make separate arrangements for the charges for those services.

I understand that we may only apply for services that the ARC physician has determined to be clinically appropriate and that ARC reserves the right to accept or reject any Patient and Spouse/Partner for this or any other of its programs and plans and/or to change the terms of The ARC Fertility Program™ prior to the purchase of any Treatment Package or plan in the Program, which occurs when I sign a Patient Participation Agreement.

I hereby authorize my physician to release all information required to process this Application and to manage The ARC Treatment Packages™, The ARC Affordable Payment Plan™, and The ARC Refund Guarantee®.

You must be an established patient at an ARC practice in order to have your application verified by a physician. This means that you must have already been evaluated by an ARC network physician.

Patient Name _____ Spouse/Partner Name _____

Signature _____ Signature _____

Date _____ Date _____

A Note on The ARC Fertility Program® and Your Health Insurance

The ARC Fertility Program® offers Treatment Packages developed by ARC physicians that are commonly accepted courses of treatment to assist you in having a child. ARC does not offer individual services or procedures—only packages. Most insurance companies or health plans, like HMO's, do not provide coverage for infertility except by individual service. If you and your Spouse/Partner choose to purchase one of The ARC Treatment Packages, you may wish to determine if your insurance company or health plan offers coverage for any part of that care and submit forms received from your physician's office for reimbursement for that care. *The lists of individual services included in each of The ARC Treatment Packages are attached to the Patient Participatio*n Agreement.

Thank you for completing The ARC Fertility Program® Application

ADVANCED REPRODUCTIVE CARE®, INC.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Advanced Reproductive Care,® Inc.(ARC) to request from and/or disclose certain protected health information (PHI) to _____(**Practice / Physician Name**). This authorization permits ARC to request and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Medical History

The information will be used or disclosed for the following purpose:

Medical Evaluation

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on 12 months from the date of signing.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that ARC has acted in reliance upon this authorization. My written revocation must be submitted to ARC's Privacy Officer at:

20195 Stevens Creek Blvd, #100
Address

Cupertino, CA 95014
City State Zip Code

Signed by:_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION