Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

Cryopreservation of Gonadal Tissue

(2018) Price List

General:

We have done our best to estimate the fees for obtaining your gonadal tissue and cryopreserving it in a cost effective manner. The standard fees and the variable fees should be combined for a realistic estimate for the cryopreservation of the gonadal tissue. The fees listed below are estimates and are subject to change without notice.

It is highly recommended that you meet with the front office of SRMS to discuss all fees so that your expectations will be met.

Fees Standard to Each CGT Patient

Consultation with SRMS Physician:

Physician Consult	$438.00

Preliminary Blood Tests:

RPR (Syphilis)	$30.00
Hepatitis B (HBsAg)	66.00
Hepatitis C (HCsAb)	94.00
HIV I & II (Human Immunodeficiency Virus)	91.00
HTLV I/II	149.00
Venipuncture	25.00
Subtotal:	$455.00

(Your referring physician is free to obtain these tests for us. It will be your responsibility, however, to make certain that we have the results to forward to XYTEX.)

Laboratory Specimen Preparation:

Hospital/Private Office Travel by SRMS Personnel	$81.00
Specimen Preparation Prior to Cryopreservation	620.00
Cryopreservation of Gonadal Tissue	492.00
Subtotal:	$1,193.00

XYTEX Transportation Fees:

Federal Express Send	$325.00
Subtotal:	$325.00

(Will probably be necessary depending upon storage space here at SRMS.)

XYTEX Annual Storage Fees:

One Year Contract	$350.00
Two Year Contract	$700.00
Three Year Contract	$1050.00
Four Year Contract	$1400.00
Five Year Contract	$1,750.00

(Choose only one for estimating initial fees.)

** These fees are paid directly to Xytex long-term storage facility. Your credit card information will be obtained for Xytex on or before baseline.

Variable Fees

General:

The greatest variable involves the obtaining of the gonadal tissue itself. As an example, if a laparoscopy is being performed as part of your medical care, additional charges will include the physician's ovarian biopsy charge. If however, the procedure to obtain gonadal tissue is entirely separate from your medical care, surgery, anesthesia and ancillary charges will be required.

For the Female Patient

Outpatient Laparoscopy:

Diagnostic Laparoscopy with ovarian biopsy - Hospital Fee (Includes Anesthesia)	$15,000.00 - $18,000
****These Fees are estimated**	
Diagnostic Laparoscopy with Ovarian Biopsy – Physician Fee	$2,685.00
Pathology Evaluation	$500.00
****These Fees are estimated**	
Approximately:	$18,185 - $21,185

For the Male Patient

Hospital Testicular Biopsy:

Urology/Surgical Consult	$300
****These Fees are estimated**	
Testicular Biopsy - Hospital Fee (Includes Anesthesia) PLUS	
Testicular Biopsy –Physician Fee	$5,500 - $7,000
****These Fees are estimated**	
Pathology Evaluation	$500.00
****These Fees are estimated**	
Approximately:	$6,300 - $7,800

Summary

Changes In Fees:

The incurred costs estimated here are not guaranteed. Individual variability often results in an unpredictable number of ultrasounds, blood tests and medication vials administered. All fees listed here are subject to change without notice.

For your convenience, Visa, Discover & MasterCard are accepted.

Any funds that were collected for procedures that **were not performed** (i.e., the procedure was canceled) will be refunded upon request within seven days of our notification. Any funds **not pre-collected** for procedures performed **that exceeded our original estimates,** will be billed at the time of service with all monies owing to be paid within thirty days of embryo transfer. Prices may vary for those with insurance coverage.

I have read the information above and our questions have been answered to our satisfaction. We agree to be responsible for the payment of charges as stated:

_____	_____	__/___/___
Patient's Signature	Patient's Name (print)	Date
_____	_____	__/___/___
Legal Guardian's Signature (When applicable)	Legal Guardian's Name (print) (When applicable)	Date
_____	_____	__/___/___
Office Personnel Signature	Office Personnel Name (print)	Date
_____	_____	__/___/___
Practitioner's Signature	Practitioner's Name (print)	Date