



Thank you for your interest in Xytex Cord Blood Bank! Please return a completed copy of your enrollment forms to Xytex Cord Blood Bank by mail to 1100 Emmett St., Augusta, GA 30904, or by fax (706-736-9720), and retain a copy of all forms for your records. Please call 877-505-4346 if you need assistance completing any part of these forms.

Client Information

Client Information

Mother's Full Legal Name (Last, First, Middle)		Date of Birth	
Street Address	City	State	Zip Code
Home Phone ()	Work Phone ()	Cell Phone ()	
Fax ()	Email		
Expected Due Date	If this is a multiple birth, please indicate number of children.		
Father's Full Legal Name (Last, First, Middle)			

OB/CNM Information

OB/CNM Name	Phone ()	Fax ()	
Practice Name	Contact Person and Title		
Street Address	City	State	Zip Code
Delivery Hospital	Hospital Phone	L&D Phone	
Hospital Address	City	State	Zip Code
How did you hear about Xytex Cord Blood Bank? (please specify)			

Complete Below Only If Applicable

Previous Xytex Client/Affiliate

Please check one:

- Xytex Corporation:
Donor # and Name of Treating Physician: _____
- Xytex Tissue Storage:
Account #: _____
- Xytex Affiliate.
Affiliation: _____

Referral

If you were referred by a Xytex Cord Blood Bank client, please indicate name of person:

Xytex Cord Trust Program

If you are eligible for the Xytex Cord Trust Program, use promo code XCT on Payment Authorization.

Xytex Cord Blood Bank
Informed Consent & Storage Agreement

General

I, _____, am electing to enter into this agreement with the Xytex Cord Blood Bank (XCB) to have my child's cord blood processed and stored by qualified personnel after the birth of my child. I understand that my medical and genetic history will be reviewed to determine my eligibility to participate in the program and I must return all enrollment information before going into labor. I also understand that I must provide samples of my blood which must be drawn within 7 days before or after birth of my child. I understand that, although infrequent, complications may occur at birth and it may not be possible for qualified medical personnel to collect my child's cord blood. My health and the health of my baby are the first priorities. XCB has provided educational material, to include alternatives, as well as information regarding cord blood preservation and will provide a collection kit.

I understand that there are benefits and risks related to the collection of cord blood. The benefits of cord blood collection include long-term storage of cord blood cells that could be used as part of a treatment program for a variety of life threatening diseases, including leukemia, certain cancers, and blood disorders. A potential risk is that therapy using cord blood cells may not be effective. Although the preservation and potential use of umbilical cord blood is expanding rapidly, the odds that a family without a defined risk will ever use their child's umbilical cord blood are low and the cord blood may never be needed. There is no guarantee that the umbilical cord blood will be a match for any particular family member or that an umbilical cord blood transplant will provide a cure. As with any transplant therapy, therapeutic success depends upon many factors beyond the stem cells themselves including patient condition, type of disease, recipient-donor relationship, matching, and other factors.

I understand there may be circumstances where the volume or the visual quality of the cord blood sample collected may, in the opinion of XCB, result in limited or no recovery of stem cells if the cord blood sample is processed. We will attempt to contact you to discuss if you wish XCB to proceed with processing. If XCB is unable to contact you, and it is the professional opinion of XCB that processing would not be valid, XCB will not process the cord blood sample (initial here: _____).

Cord Blood Testing

I understand that XCB will perform cell viability, cell counts, blood typing and bacterial and fungal tests on the cord blood to determine the nature and quality of the cord blood. I will receive a final report detailing these results. I will have the opportunity to discuss these results and will be given the option to continue or discontinue permanent long term storage.

Infectious Disease Testing

I understand that my blood will be tested for certain infectious diseases [including human immunodeficiency virus (HIV), hepatitis B and C viruses, human T-lymphotrophic virus (HTLV), cytomegalovirus (CMV) and syphilis] as required by various regulatory agencies. If any of these tests are abnormal, I authorize XCB to provide these test results to me, to my physician and to government agencies as required by law. I understand that XCB will not permanently store the cord blood of a client who is HIV, HTLV or HBsAg confirmed positive. At this time, a confirmed positive test result for other infectious diseases does not mean that the cord blood will be rejected.

Payment

Upon accepting the terms of this agreement, I agree to pay the fees associated with processing and storage of my cord blood unit according to the payment plan that I select and according to the fees listed in the payment authorization form. XCB reserves the right to increase the storage fee to accommodate any reasonable cost increases we may incur. In the event that my cord blood is not collected, I understand that all fees will be refunded except the enrollment fee (initial here: _____). Additionally, I understand that if my cord blood is collected and processed and I choose not to store, then I will be charged a \$300 processing fee and my enrollment fee will not be refunded (initial here: _____). Additional express medical courier charges may apply in certain circumstances, including geographic location, holiday or weekend delivery/pickup, which requires a premium shipment charge (up to \$200 – initial here: _____).

This agreement shall be in effect as of the date I indicate by my signed signature below. The agreement will remain in force until I either request my units for transfer to another storage facility, I request units for transplantation, I request to terminate this agreement or there is a change in ownership. XCB may terminate this agreement, after notifying me, for nonpayment, after appropriate notification. When units are requested, I will be responsible for any transfer or shipping fees.

Liability

I acknowledge that alternative and comparable storage services are available from other cord blood banks and that XCB's rates are based on the limitations of liability and the indemnity contained herein.

Except in cases of XCB's gross negligence or willful misconduct, XCB shall have no liability to me, or any designated recipient, or my heirs, estate, legal representatives, spouse or any person claiming through any of them, whether in contract or in tort or under any other legal theory, for any damages, costs or expenses (including any indirect, special, incidental, consequential or similar damages), arising out of or in connection with this Agreement or XCB's performance or nonperformance of its obligations hereunder, even if XCB has been advised of the possibility of such claim.

I agree that XCB will not be held responsible for any loss, degradation or destruction of the cord blood unit resulting from circumstances outside XCB's reasonable control, including without limitation, natural disasters, severe weather, fire, explosions, non-temporary power failures, national emergencies, strikes or other labor disputes, government regulations or other similar events. Furthermore, I agree that XCB will not be responsible for anything outside XCB's reasonable control, including without limitation, delay, loss or damage by a courier transport service during transit, incorrect preparation or contamination during collection, loss of cord blood due to incorrect thawing or non-use after thawing or other circumstances that may prevent XCB from meeting the terms of this agreement.

Without limiting any other provision hereof, in no event shall XCB's liability under this Agreement exceed the total fees paid to XCB for the most recent storage year.

Without limiting any other provision of this Agreement, I hereby irrevocably release and discharge XCB, its employees and agents from, and forever waive, any and all claims, now or hereafter arising out of or related to the damage, destruction or loss of any or all collected cord blood, except to the extent caused by XCB's gross negligence or willful misconduct, or the physical appearance of any abnormalities, hereditary characteristics or any other adverse consequences, including the transmission of infectious or genetic disease, which may arise in connection with or as a result of transplantation using collected cord blood, except to the extent caused by XCB's gross negligence or willful misconduct.

I agree not to sue or bring other legal action against XCB, and shall not aid or abet anyone else in suing or bringing legal action against XCB, for or on account of any claim which may arise out of the use, storage, release or destruction of cord blood, except to the extent arising out of XCB's gross negligence or willful misconduct.

I agree to indemnify and hold harmless XCB, its employees and agents, from and against any and all losses, demands, judgments, claims, liabilities, expenses, or damages (including attorneys' fees and amounts paid in settlement) incurred in connection with any claim, legal action or defense arising out of the use, storage, release or destruction of said cord blood, including, without limitation, any claim or legal action brought by any person claiming a right of ownership or possession in or to any cord blood or by any recipient resulting from transplantation using any cord blood, except, in each case, to the extent arising out of XCB's gross negligence or willful misconduct.

In the event of any dispute with respect to ownership or possession of cord blood, XCB shall be entitled to tender cord blood into custody of the United States District Court for the Southern District of Georgia and to initiate such legal proceedings as it deems appropriate, and thereupon to be discharged from all further duties and liabilities under this Agreement. The filing of any such legal proceedings shall not deprive XCB of any compensation earned under this Agreement prior to such action.

Confidentiality and Disclosure of Health Information

I understand that appropriate confidentiality will be maintained for all patient records concerning the Service, but that the U.S. Food and Drug Administration, U.S. Department of Health and Human Services or other government agencies may inspect records in accordance with applicable federal, state or local laws or regulations. I consent to XCB's use and disclosure to my medical care provider and to state agencies (if required) of my infectious disease test results for the purpose of XCB's service procedures or as required by law.

I understand that my medical care provider may disclose to XCB and its representatives health information relating to my pregnancy and delivery and to my child, which is needed to ensure that the umbilical cord blood and maternal blood is collected and stored properly, to coordinate the delivery of the umbilical cord and maternal blood to XCB and to facilitate medical care provider or hospital reimbursement. I understand that my medical care provider will not continue to disclose any information about me once the umbilical cord and maternal blood have been tested and the cord blood unit is successfully stored. All information and test results obtained by XCB may be used where confidentiality is maintained and data blinded except as required by federal or state law. I understand that XCB agrees to protect my identifiable health information by using and disclosing it only for the purposes authorized above or as required by law. These limitations continue even after cancellation or termination of the Enrollment Agreement.

Ownership

I understand that I am the custodian of the cord blood unit until my child reaches the age of 18, after which, the child, he or she will become the custodian of the cord blood.

I understand that my legal rights and XCB's obligations concerning the disposition of the cord blood after my death are unclear at this time in Georgia. Because of this uncertainty, I agree that neither XCB nor its employees or agents will be responsible or liable in the event that XCB does not comply with my wishes regarding the disposition of my cord blood upon my death. Nonetheless, I understand that XCB would like to know my wishes concerning the disposition of the cord blood upon my death so that they may attempt to comply with my wishes if they are legally permissible at that time. So that XCB might know my preferences, I have checked the following:

In the event of my death, I would prefer that, and authorize XCB to and in accordance with any laws at the time of my death,

- () a. Transfer ownership of cord blood to the legal guardian of the child (upon presentation of death certificate or other evidence of my death satisfactory to XCB in its sole discretion) as listed here: _____.

- () b. Transfer ownership of cord blood to my spouse (upon presentation of death certificate or other evidence of my death satisfactory to XCB in its sole discretion) as named here: _____.
- () c. In the event of my death and my spouse's death, simultaneously, and upon presentation of death certificates or other evidence of our death satisfactory to XCB in its sole discretion, I would prefer that and authorize XCB to transfer ownership to the legal guardian of the child.
- () d. In the event of my death and the death of my spouse and upon presentation of death certificate or other evidence of our death satisfactory to XCB in its sole discretion, destroy cord blood.

I also understand that if storage fees are not paid within 30 days of invoice, all rights, title and ownership of the cord blood will be relinquished to XCB. XCB may, at its discretion, use said cord blood for research purposes or discard once this agreement has been terminated for nonpayment.

Withdrawal

I understand that I may elect to withdraw from participating in the XCB program at anytime, understanding that the terms and conditions of this agreement stated herein will remain in effect, by notifying XCB in writing at 1100 Emmett Street, Augusta, GA 30904.

Any changes to this agreement must be in writing and agreed upon by both parties.

I have read and understand the information in this agreement and desire to enroll in the cord blood program. I fully understand the Terms and Conditions of this Informed Consent/Storage Agreement, the risks, benefits and alternatives of this program, and the Confidentiality and Disclosure of Health Information. All of my questions regarding this service have been answered to my satisfaction. I certify that all the information I have provided to XCB is true and correct to the best of my knowledge. I have signed this agreement freely and voluntarily.

Print Mother's or Guardian's Full Legal Name

_____/Date_____
Signature of Mother or Guardian (Full Legal Name)

_____/Date_____
Signature of Reviewing XCB Personnel

HIPAA

Notice of Privacy Rights and Practices

This “Notice” is intended to tell you, a patient, about our relationship to you. “We” means Xytex Cord Blood Bank, providing cord blood services for you.

The United States government enacted a law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that requires us to let you know about our Privacy Practices. Xytex, as a member of the medical community, upholds your right to keep private information about your medical status confidential. Specifically, we are talking about personal identifiable health information (PHI) that is protected by HIPAA. We want you to know in advance how we can use the PHI we obtain about you, who might have legitimate access to this information and your rights to privacy. We want you to know your rights to obtain copies of your PHI in our files and to change this information. We also want you to know the safeguards we have taken to protect your PHI. You have the right to approve or to block the release of PHI except when the release is required by government order. Xytex has the right to change its policies about your PHI we already have as well as any PHI about you we are given in the future; therefore, we have the right to change this “Notice.”

Before we can assist you medically, we ask you to sign a statement that you have received this notice and have been given an opportunity to have your questions about it answered.

Examples of How We May Use Your PHI

HIPAA is a lengthy document. Here we give you a few examples of how the law allows us to use your PHI. Regardless of the limited number of examples, Xytex will make its best efforts to respect the privacy of your PHI in compliance with all applicable requirements of HIPAA.

WHO IS ENTITLED TO OBTAIN YOUR PHI IN FILES AT XYTEX?

- You (unless the information would be harmful to you).
- Any representative of the Secretary of the U.S. Federal Department of Health and Human Services that is checking up on our compliance with HIPAA.
- Any public health authority permitted by law to collect or receive your PHI.
- Any person authorized by a judicial court order to obtain your PHI.
- Any person authorized to obtain your PHI in compliance with workers' compensation laws and other similar legally established programs.

WE WILL ALSO RELEASE YOUR PHI TO THE FOLLOWING:

- The physician or medical practice that you have provided to us.
- To any other physicians or health care professional assisting with cord blood banking and/or transplant services.
- To “third parties” responsible for paying for your medical services. To “third parties” providing administrative services for us (such as billing or word processing) who are recognized by HIPAA as being “business associates.” Our business associates have agreed, in writing, to protect the privacy of any PHI made available to them.
- To parents, guardians and persons acting in a similar legal status for minors as defined by Georgia state laws.

THE SECURITY OF YOUR PHI

- Under no circumstances will your identifying information be provided to entities outside of Xytex except as required by law or by your written permission.
- We maintain a physically and electronically secure office to ensure that your PHI is not placed at an unreasonable risk. When paper files are not actively being used they are locked in a vault. Our electronic files are maintained in a secure server and your financial record is protected by Authorize.net.
- Our staff is instructed about our privacy policies and practices. Should any employee at Xytex be found in willful violation of these measures, he or she is subject to termination without recourse.

YOUR RIGHTS REGARDING YOUR PHI

Xytex, at its corporate office in Augusta, Georgia has, designated a HIPAA Privacy Officer to respond to your HIPAA related requests. These requests should be written. When you give us proper contact information, you will receive a response from the Officer within 10 business days (Monday through Friday excluding holidays for Xytex employees).

- **Right to inspect and copy** with physician approval. Physician approval is a requirement of the state of Georgia. You may inspect our file of your PHI including medical and billing records. You may request us to provide you with a copy of any of these records for a nominal fee per each side of a page (8.5 inches x 11 inches). This right of inspecting and making copies of your records does not include information that Xytex has gathered for formal resolution of a dispute (such as court proceedings) nor does it include PHI that is restricted by law. You may not remove our original records of your PHI from Xytex.
- **Right to limit access.** You may ask us not to use or release any part of your PHI that is requested for treatment, payment or "health care operations" as defined by HIPAA. Your written request to our HIPAA Privacy Officer must specify: 1) what information you want restricted; 2) whether you are restricting our use, disclosure or both; 3) whose access is restricted (for example, your spouse); and 4) an expiration date. If we believe your request is not in your best interest, or if we cannot reasonably accommodate your request, we can deny your request. If we agree to your request, it will be honored except if the PHI is needed to provide emergency treatment (to you or someone else) At your written request, we will remove restrictions that you initiated.
- **Right to request changes.** If you believe that our records of your PHI are incorrect or incomplete, you may request in writing that we change these records. HIPAA does not require us to make the changes you request.
- **Right to a list of disclosures.** You may request us to provide you with a list of disclosures we have made of your PHI. This right applies only to disclosures made for purposes other than treatment, payment or health care operations. This list will only include disclosures made after April 14, 2003, and no more than six years from the date of the request. This right excludes disclosures made to you, your physician, to family members or friends involved in your care of for notification.
- **Right to obtain a copy of this Notice.** You may obtain a paper copy of this notice from our corporate office in Augusta, Georgia.

COMPLAINTS

If you believe your privacy rights at Xytex have been violated, you may file a written complaint with our HIPAA Privacy Officer or with the U.S. Department of Health and Human Services. No retaliation will occur against you for submitting a complaint.

<p>Office for Civil Rights Department of Health and Human Services 61 Forsyth Street, S.W. Suite 3B70 Atlanta, GA 30323</p>

<p>HIPAA Privacy Officer Xytex Cord Blood Bank 1100 Emmett St. Augusta, GA 30904</p>

**Client Acknowledgement of Receipt of Xytex Cord Blood Bank
 Notice of Privacy Rights & Practices**

I acknowledge that I have read a copy of Xytex's Notice of Privacy Rights and Practices and have the opportunity to retain a copy for my records.

_____ Date: _____
 Print Client Name

_____ Date: _____
 Signature of Client or Personal Representative

Please retain a copy of the HIPAA Notice of Privacy Rights & Practices for your records.

Xytex Cord Blood Bank
Payment Authorization

Client's Name: _____

If you have a Promotional Discount Code, please identify the code number: _____

If you are a previous Xytex Client or a Xytex Affiliate, please call us for special pricing information at 1-877-505-4346 or email us at tissues@xytex.com.

Step One: Select a Payment Option

	Standard
Single Payment	<input type="radio"/> \$1,875 at enrollment
Two Interest-free Payments	<input type="radio"/> \$175 at enrollment and \$1,700 paid 30 days prior to due date
Three-month No Interest Plan	<input type="radio"/> \$175 at enrollment and \$566.67 (estimated) in three monthly payments
One-time 18-year Prepaid Plan	<input type="radio"/> \$3,305 (Initial fees plus 18 years of storage at \$1,530—a 15% savings)

Step Two: Select an Additional Option (if applicable)

	Standard
Multiple Births	<input type="radio"/> \$1700 for each additional child

Step Three: Select a Payment Method

- My check is enclosed. *Please make check payable to Xytex Cord Blood Bank.*
 Please bill my credit card.

Credit Card: Visa MasterCard Discover American Express

Card Number	Security Code	Expiration Date
Name on Card		
Billing Address	City	State Zip Code

Signature _____ Date _____

Xytex Cord Blood Bank Gift Program (if applicable)

Your Name	Relationship	Recipient Name
Address		Address
City	State Zip Code	City State Zip Code
Phone		Phone

Return these forms:
By mail: Xytex Cord Blood Bank, 1100 Emmett Street, Augusta, GA 30904
By fax: 706-736-9720