

Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics



Cryopreservation of Sperm *Price List*

Elective vs. Cancer/Surgery/Radiation/Chemotherapy:

A single specimen (Preliminary Semen Testing below) may be the only charges for those patients who are electively freezing a specimen for an upcoming IUI/IVF procedure.

For patients with cancer and other indications for cryopreservation, the entire price list below pertains to them. Initial charges including shipping and handling fees will be billed to SRMS. The patient is billed directly from XYTEX for the storage fees. Payment is respectively requested at the time of service.

Consultation with SRMS physician:

Physician Consult \$246.00

Preliminary Blood Tests:

RPR (Syphilis)	\$27.00
Hepatitis B (HBsAg)	60.00
Hepatitis C (HCsAb)	85.00
HIV (I & II)	82.00
HTLV I/II	135.00

Subtotal: \$389.00

(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.)

*Preliminary Semen Testing:

Cryopreservation, sample #1	415.00
Cryopreservation Survival Factor	67.00

Subtotal: \$482.00

* These may be the only fees for those cryopreserving to short-term use.

Each Additional Specimen:

Semen Analysis & Cryopreservation	\$415.00
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Subtotal: \$415.00

XYTEX Transportation Fees:

Federal Express Send	\$150.00
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Subtotal: \$150.00

XYTEX Annual Storage Fees:

One Year Contract	\$300.00
Two Year Contract	\$500.00
Three Year Contract	\$700.00
Four Year Contract	\$900.00
Five Year Contract	\$1,100.00

(Choose only one for estimating initial fees.)

Total Estimated Costs Based on Two Specimens:

One Year Contract	\$1,982.00
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Note: An additional storage fee will be charged to persons wishing more than three ejaculates stored.

Changes In Fees:

The incurred costs estimated here are not guaranteed. **All fees listed here are subject to change without notice.**

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

Any funds that were collected for procedures that **were not performed** will be refunded upon request within seven days of the conclusion of your cycle.

Any funds **not pre-collected** for procedures performed **that exceeded our original estimates,** or for **possible or post transfer fees,** will be billed at the time of service with all monies owing to be paid within thirty days of embryo transfer.

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

_____	_____	Date	___/___/___
Patient's Signature	Patient's Name (print)		

_____	_____	Date	___/___/___
Partner's Signature	Partner's Name (print)		

_____	_____	Date	___/___/___
Office Personnel Signature	Office Personnel Name (print)		

_____	_____	Date	___/___/___
Physician's Signature	Physician's Name (print)		