CORD BLOOD BANK OF ARKANSAS (CBBA)

Private Family Cord Blood Storage Program

We appreciate you choosing CBBA for your private cord blood storage needs. Please take a few minutes to complete the attached forms required for private family cord blood storage by following the instructions below.

How the Storage Program Works:

1. Read and sign the attached cord blood storage agreement and consent forms where appropriate. Please note that some forms require the signature of your physician or nurse/midwife. Also instruct your physician/midwife to complete the physician/midwife CB collection inquiry form, which you will return to CBBA with all completed forms.

2. We are required to test your blood for infectious diseases from a sample collected within 48 hours of the baby's birth, even if you have had previous prenatal testing done. Tubes for the collection of your blood are included in the kit, and your blood will be drawn around the time of delivery by the hospital or birth center staff. **All test results are confidential.** If the results are needed for a specific reason, they will be provided to your physician with a written request. You and your physician or nurse/midwife will be notified of any abnormal results via certified mail. *Please note: It may be necessary to report certain positive test results to the Arkansas Department of Health.*

3. Please return all required forms with original signatures along with payment (see fee schedule) to CBBA. To expedite the process, you may setup your account by phone using a credit card. The CBBA coordinator will give you further instructions if you choose this option.

   Mail the forms to:
   The Cord Blood Bank of Arkansas
   University of Arkansas for Medical Sciences
   4301 W. Markham St., slot #503-1
   Little Rock, AR 72205

4. Upon receipt of required forms and payment, we will issue you a cord blood collection kit, which includes collection instructions for your physician or nurse/midwife. Collection kits will be shipped to the address provided unless notified otherwise. Please inform CBBA if there are any changes in your address, phone number or delivery due date.

5. Notify CBBA upon the labor and delivery of your baby at 1-855-854-2222 or after hours/weekends at 1-501-766-4611. **It is your responsibility to insure that we are notified.** We will dispatch a courier to pick up the cord blood.

Contact us for more information or questions regarding the private family cord blood storage program.

CBBA
CORD BLOOD STORAGE AGREEMENT

I, _____, (hereinafter called client), do hereby enter into this contractual relationship for the processing and storage of my newborn's umbilical cord blood with CBBA, this _____ day of _____ of 20___. I have had the opportunity to have my questions answered to my satisfaction. The terms and conditions are as indicated below and are mutually agreed upon and changeable only in writing. I am enclosing the first year's storage, shipping, and processing fees and have enclosed the required forms. I certify that the information I am providing is true and accurate to the best of my knowledge.

I acknowledge that I have been provided with a copy of the “Notice of Privacy Practices” of CBBA.

PURPOSE

CBBA intent is to make the client's cord blood available primarily for future elective needs for which cord blood technology at that time allows. The client's cord blood may also be made available, (upon written consent of the client), to relatives or other persons designated by the client. Current technology allows cord blood cells to be used as bone marrow stem cells would. Although the probability of your baby needing cord blood cells is currently low, technology is evolving and the cord blood cells can only be collected at the time of birth.

Umbilical cord blood storage includes the following:

> ***TESTING -*** Food and Drug Administration (FDA) mandated testing of maternal blood and the umbilical cord blood to determine if it can be stored and transfused.
> ***CRYOPRESERVATION -*** The initial processing of the umbilical cord blood to separate and concentrate the cells, and the preparation of the cells for freezing and the freezing of the "cord blood" in liquid nitrogen.
> ***STORING -*** Maintaining the frozen "cord blood" in the vapor phase of liquid nitrogen.

To have the cord blood cells obtained and processed, the client agrees to notify her physician as to this desire and obtain a physician's order from her physician, to complete the agreement and accompanying forms in their entirety including the consent for collection of the cord blood and the consent for appropriate blood testing on the mother's blood and on the cord blood (including HIV, HBV and other infectious disease agents) as required by the FDA.

COLLECTION

Cord blood will be collected by the client's physician, midwife, nurse or CBBA trained collector using methods approved by the CBBA Medical Director. The cord blood will then be packaged for transportation (shipping), to CBBA processing and cryopreservation laboratory for processing and storage. Processing and storage is performed under strict laboratory conditions within 48 hours of delivery of your child to ensure the highest yield of cord blood cells possible. Your cord blood cells will be stored in the vapor phase of liquid nitrogen.

Sometimes, your physician may not be able to obtain more than 40 cc. of cord blood (currently the minimum useable amount). In this case you will be informed as early as possible and provided with the option to store the cord blood cells as investigation is currently proceeding in the growth of the cord blood cells outside of the body.

PAYMENT

I agree to pay CBBA the initial fees and the continued yearly storage fees as described in the fee schedule enclosed herein. I further agree to pay all reasonable shipping charges which may vary in amount as necessitated by my location and the time and date of my delivery, (evening, weekend, holiday etc.). This contract is automatically renewed unless a written **notarized** letter is received. It is the responsibility of the client to notify CBBA with address and phone number billing data changes.

CLIENT RESPONSIBILITIES

In order to allow CBBA to store the umbilical cord blood I agree to fulfill the following responsibilities: 1) Sign the cord blood storage agreement; **2)** Complete the health questionnaire; **3)** Sign the informed consent/ release form; **4)** Sign the Hospital/ Birthing Center and Physician consent and release form; **5)** Sign the consent form for Infectious Disease testing (CBBA tests your blood for infectious diseases. **(All test results are confidential)**; **6)** Provide CBBA with the physician's order for blood testing (Rx enclosed); **7)** Provide CBBA with maternal blood (to be drawn during labor and delivery) for testing; **8)** Keep CBBA informed as to your address and the delivery due date of your baby; **9)** Notify CBBA upon the delivery of your baby, by day at 1-855-854-2222 or, nights and weekends at 501-766-4611, as soon after the birth as possible (within 2 hours) so that we can send a courier to pick up the cord blood for processing; **10)** Pay CBBA as described on page 5 of this agreement.

RETRIEVAL FOR USE

To obtain the stored cord blood for use by the client or the client's designee, the client must contact CBBA during normal business hours (8:00 a.m. to 3:30 p.m. CT 1-855-854-2222 or 501-766-4611). CBBA will make a good faith effort to complete the retrieval and shipping as soon as can be arranged. The client or the client's designated representative shall have the option of designating a shipper to pick up the stored cord blood at the CBBA office. Otherwise, CBBA shall ship the cord blood in a manner and with a shipper selected by it to provide safe and timely service. The client shall pay all shipping and preparation costs.

LIABILITY

During basic collection and processing, your physician and CBBA will be using a blood collection system and collection equipment made by outside suppliers and transportation systems from outside suppliers. Cord blood collection will be performed by your attending physician, physician's designee or nurse/midwife and the amount of cord blood collected is variable and cannot be predicted. Additionally, there may arise circumstances beyond CBBA's control (of maternal or neonatal nature), which might preclude the collection of the cord blood, or circumstances based on blood testing results which preclude the storing of the cord blood (as directed by the FDA). In all such cases, CBBA's liability to a client, (or designated recipient of client's cord blood), will be limited to a partial refund. (See enclosed price schedule for refund information.) If the cord blood is collected, CBBA will make a good faith effort to ensure that due care and diligence will be utilized in the preparation and storage of the client's cord blood. CBBA shall not be held responsible for damage or loss of the cord blood due to acts of war, national emergency, anarchy, acts of nature or acts of God. Furthermore, CBBA will not be liable for anything beyond its direct control including but not limited to: loss by a carrier, contamination in shipment, accidents in shipment, misuse, untimely use, contamination at other premises, incorrect preparation at other premises, loss of the cord blood due to non-utilization after thawing, or other acts or conditions that prevent CBBA from complying with its undertakings. CBBA shall not be liable for any incidental or consequential damages resulting from loss of the cord blood. In any event, CBBA's liability shall be limited solely to a refund of the fees paid to it for collection and preparation of the cord blood.

I am aware that there is no guarantee as to the success of treatment or that the cord blood cells will be a usable or appropriate treatment for any potential disease or disorder which may occur in the future. I am also aware that there is no guarantee that treatment with cord blood cells will be the most appropriate treatment for any condition which arises and that there may be more recently developed treatment modalities in the future which may be more advantageous.

All disputes that may arise in connection with this Agreement that are not resolved by the parties themselves shall first be submitted to mediation in the State of Arkansas under the rules and regulations related to mediation under Arkansas law. If such disputes are not settled by mediation, then the dispute shall be submitted to arbitration under the rules of the American Arbitration Association. The decision of the arbitrators shall be binding and conclusive and may be enforced by the prevailing party in whose favor it runs in any court of competent jurisdiction.

This Agreement and any disputes arising under it shall be construed, enforced and interpreted in accordance with the laws of the State of Arkansas. This Agreement shall be binding upon and inure to the benefit of the parties hereto, and their successors, legal representatives and assigns. This Agreement contains the entire agreement between the parties. Any agreement, modification or addition hereto must be in writing and signed by both parties to be effective.

TERMINATION PROVISIONS

This agreement automatically continues storage unless a notarized written request to terminate storage is received. CBBA must receive the original notarized document. If I fail to pay the fees due, CBBA shall notify me in writing that I am in default and I shall have thirty days to pay the arrears in full, or the agreement is terminated. I understand that it is my responsibility to notify CBBA of any address changes that occur. I may terminate this agreement at any time. I understand that initial processing, storage and shipping fees for the first year are non-refundable once the cord blood has been processed. Should I terminate the agreement I have the right to specify in writing the disposition of the cord blood, and I shall bear any associated costs. If I do not specify the disposition or if I am in default in payment, CBBA shall retain all rights to the cord blood. I will ***not*** be entitled to any refund should I terminate this agreement.

ACCEPTED BY CLIENT:

_____
(Client or Legal Guardian) Signature

_____
Print Name

Witness:

_____
Witness Signature

_____
Print Name

ACCEPTED FOR
CBBA:

_____
Signature

_____
Print Name and Title

PRIVATE STORAGE ENROLLMENT FORM

IMPORTANT: Please print clearly and complete all that apply.

PAYMENT AGGREGEMENT

Total First Year Costs ***$1,499***

Includes these standard services:
(Prices do not reflect any discounts or promotions. Call for details.)

- ✓ **Enrollment**
- ✓ **Collection Kit and Processing**
- ✓ **Standard Shipping and Handling***
- ✓ **First Year Storage**

***Additional Fees Apply when:**

- o Express Medical Courier services will be used when the unit can not be delivered to our lab for processing within 48 hours. This may include deliveries taking place on weekends, holidays or any other day or time which FedEx pickup can not be scheduled. As our client, you will be balance billed the courier fee. (We do not add to that fee).
- o Client directed Express Medical Courier. Call for pricing.
- o FedEx Priority Next Day delivery of collection kit $50.

Annual Storage Fee* ***$120***

Billed annually on first day of your child's birth month for as long as the unit remains in storage. Annual storage fee subject to change. Notice will be provided in advance of any fee increase.

Advanced Storage Pre-Pay Plans:

Pre-paid storage options allows the client to "lock in" annual storage for the term selected below. The selected term begins *after* the first year of storage which is included free in the first year fees.

- ✓ 5 years for $570 **Save $ 30**
- ✓ 10 years for $1,080 **Save $120**

PAYMENT OPTION	INCLUDED	AMOUNT DUE
SINGLE PAYMENT By check or credit card.	Collection, Processing, Standard Shipping & 1st year storage	**$1,499.00**
ADVANCE PAY STORAGE. Choose 5 or 10 year plan and lock in your rate. Add this to your Flex-Pay Plan for more savings.	Fixes cost for annual storage for the period chosen. In addition to the first year of storage already included.	**5yrs=$570** **10yr=$1080**
FLEX-PAY PLAN – Deposit plus 6 month Zero Interest flex plan to pay balance due. Requires a valid credit card.	Collection, Processing, Standard Shipping & 1st year storage	Minimum $500 deposit. Balance and installments determined by deposit paid

SELECT OPTION BELOW

_____ SINGLE PAYMENT

_____ ADVANCE PAY STORAGE ___5yrs __10yrs

_____ FLEX-PAY PLAN

**Additional fees due to uncommon circumstances, such as international fees, adoptions or surrogacy cases may apply. These fees will be discussed at setup should they apply.*

COMPUTE YOUR TOTAL COST HERE:

First Year Costs	$1,499.00
Less Discount _____n/a_____	($__n/a__) Promotion Name:_____n/a_____
(Only 1 discount per order)	
Add Advanced Pay Storage	$_____
Add Additional Fees (express shipping, etc.)	$_____
Total	**$_____**
Flex-Pay Plan Deposit (min $500)	($_____)
Balance	$_____
Balance/6 = monthly payments*	$_____

NOTE: **payments start the month following client enrollment date. Last payment may be adjusted for rounding.*

Client Signature: **Date:** **SSN# *(required)*:**

Credit Card Authorization: I hereby authorize CBBA to charge the following credit card account in accordance with the plan selected above, and apply said charge towards the payment of the charges I owe CBBA. I understand that I will remain responsible for recurring charges and additional late fees should my credit card be cancelled or otherwise made unavailable for payment. Should I cancel this contract for any reason prior to processing the cord blood unit (including voluntary cancellation or inability to collect the blood), CBBA will retain a $150 administration fee and any additional shipping fees or fees due to uncommon circumstances. The remainder will be returned to the client or paying party.

Payment Options (*please check one of the options below*): **TOTAL AMOUNT DUE: $_____**

□ Check #_____ Enclosed Flex-Payment *(circle)*: Yes / No **Deposit Due Now*:** $_____

**minimum $500 deposit due if using Flex-Pay*

Credit Card (*please ck one*): □ VISA □ MasterCard □ American Express □ Discover

Name On Card: _____ Expiration Date: _____

Billing Address: _____, Apt #____ St: _____ Zip:_____

Credit Card #: _____ 3-Digit Security #: _____

Authorized Signature: _____ Today's Date: _____

CBBA
INFORMED CONSENT AND RELEASE

I have read and understand the information enclosed in the package and understand that I am electing to purchase the cryopreservation of the umbilical cord blood cells of my soon to be born baby. I understand that these cells can currently be used to reconstitute the "bone marrow" cell population of my baby or possibly someone else in my family at a future date if that should become necessary. I further understand that the science of cord blood transplantation is a new, evolving science and that other newer uses may or may not become available in the future.

I have had the opportunity to receive information about the cryopreservation and I am satisfied with the information. I have also had the opportunity to talk with the staff of CBBA. I am aware the medical confidentiality will be observed but the Department of Health and Human Services, Food and Drug Administration or other governmental agencies or accrediting bodies (such as AABB) may need to inspect the records according to the appropriate governmental rules and regulations at the State, Federal or International level.

I agree to undergo the procedures necessary to accomplish the cryopreservation as outlined in the cord blood storage agreement and as follows:

1. Complete and return to CBBA the entire Cord Blood Storage Agreement, including the informed Consent and Release, Health Questionnaire, Informed Consent for Infectious Disease test and Physician's Order for blood testing.
2. Provide CBBA with a sample of my blood for testing (to be drawn at the delivery).
3. Provide my physician with signed copies of the Informed Consent and Release, Informed Consent to the Infectious Disease testing and the Hospital Informed Consent and Release.
4. To have my physician draw the umbilical cord blood following the birth of my baby.
5. Notify CBBA of the delivery of my baby.
6. Keep CBBA notified as to my current address and contact information.
7. Pay CBBA according to the Cord Blood Storage Agreement.

I have the right to withdraw from the cryopreservation at any time as indicated in the terms of the Cord Blood Storage Agreement.

I am entering into the Agreement on a voluntary basis and on behalf of my unborn baby and myself understand that cryopreservation of cord blood is a new medical procedure. I further understand that there is no guarantee or assurance of the success of the service in curing any potential future disease entity. I on behalf of my unborn baby and our heirs, successors and assigns hereby release and forever hold harmless CBBA and its affiliates, assigns, officers, directors, employees and agents and their successors from any and all actions, causes of action, claims, demands, liabilities, covenants omissions and damages and any and all other claims of every kind, description or nature both in law and equity which may arise relating to my and my unborn baby's participation in the cryopreservation service. I am aware that I have the right to seek legal counsel and if I elect not to seek counsel I acknowledge that I understand the terms of the Informed Consent/Release and the ramifications thereof.

Signature (Expectant Mother) Date	Signature (Witness) Date
Print Name (Expectant Mother)	Print Name (Witness)

INFORMED CONSENT AND RELEASE-HOSPITAL/BIRTHING CENTER

I, the undersigned, desire the collection of my unborn baby's cord blood for storage. I have elected to utilize the services of CBBA to achieve the desired storage. For the storage to occur it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my baby, rather than discard the blood as medical waste. The collected cord blood will be shipped to CBBA for processing and placement into storage.

My physician, physician's designee, nurse/midwife or CBBA trained collection specialist will perform the collection of the cord blood after the deliver of my baby, while the delivery of the placenta occurs. He/she will use methods provided by CBBA in their standard operational procedures. The Hospital will not be involved in the collection of the cord blood and will not provide or be responsible for providing equipment or personnel to accomplish the cord blood collection. Medical conditions may arise which preclude the collection of the cord blood and will be decided at the sole discretion of the attending physician.

I understand that the storage of cord blood includes medical procedures and that there can be no guarantee or assurance of success of the results of the service, I further, on behalf of myself and my unborn baby, or respective heirs, successors and assigns, hereby release and forever hold harmless the Hospital/Birthing Center, and it affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of action, claims, debts, demands, liabilities, covenants, controversies, omissions and damages and any and all other claims of every nature and description whatsoever, both in law and equity, which may arise relating to the collection of the cord blood on behalf of me and my unborn baby.

INFORMED CONSENT AND RELEASE – PHYSICIAN

My patient desires to obtain her unborn baby's cord blood for storage on behalf of her and the unborn baby. She has elected to utilize the services of CBBA to achieve the desired storage. For the storage to occur, it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my patient's baby, rather than discard the blood as medical waste. The cord blood obtained will be shipped to CBBA for processing and placement into storage.

I will perform the collection of the cord blood after the birth of her baby, while the delivery of the placenta occurs. I will use the methods provided by CBBA in their standard operational procedures. The collection period will be brief and CBBA will provide the protocols and collection equipment in the kit. I will make a good faith effort to acquire as much cord blood as is feasible and will minimize the risk of fungal, bacterial or maternal blood contamination.

The health and welfare of my patient and her baby are my primary concerns and responsibility and accordingly I reserve the right to forgo the collection of the cord blood if my best medical judgment indicates this to be necessary.

I understand that the storage of cord blood includes medical procedures and that there can be no guarantee or assurance of success of the results of the service. I, on behalf of myself, my heirs and successors and assigns hereby release and forever discharge CBBA and its affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of actions, demands, debts, claims liabilities, covenants and damages and any and all other claims of every kind, nature and description whatever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

CBBA, on behalf of itself, it affiliates, assigns, officers, directors, employees and agents releases and forever discharges me and each of heirs, successors and assigns from and all actions, causes of actions, demands, debts, claims liabilities, covenants, and damages and any all other claims of every kind, nature and description what ever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

My patient, _____ , release me and each of my heirs, successors and assigns form any and all actions, causes of action, claims, debts, demands, liabilities, covenants, controversies, omissions and damages and any and all other claims of every kind, nature and description whatsoever, both in law and equity, which may arise relating to my performing the collection of the cord blood.

_____	_____	_____	_____
Signature of Expectant Mother *(Required)*	**Date**	**Signature of Physician/Midwife (*(Required)***	**Date**
_____		_____	
Print Full Name of Expectant Mother		Print Name (Physician/Midwife)	

IMPORTANT: THIS PAGE IS REQUIRED TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CBBA CORD BLOOD DONATION COLLECTION KIT. TO AVOID ANY DELAYS IN YOUR PAPERWORK REVIEW, PLEASE ENSURE THAT ALL REQUIRED SIGNATURES ARE PRESENT PRIOR TO SUBMITTING YOUR FORMS.

INFORMED CONSENT FOR INFECTIOUS DISEASE TESTING

HUMAN IMMUNODEFICIENCY VIRUS AND TRANSMISSION:

Human Immunodeficiency Virus (HIV) is a virus which can be transmitted from individuals through body fluids, primarily blood and semen. The spread is not through air or food or by casual social contact. It is passed on when the blood or body fluids of an infected person mix with your own. Sexual transmission is mainly the result of the transfer of and exposure to infected semen. Women as well as men can transmit the virus sexually. The HIV virus has also been detected in vaginal secretions, tears, and saliva, but exposure to saliva has not been proven to transmit the infection. Intravenous drug users and persons receiving blood transfusions can be exposed to the virus through infected blood or body fluids. A baby may become infected during pregnancy, delivery, or when breast feeding if its mother has the disease. A person may carry the virus for months before testing positive and may carry the virus for months or years before the symptoms appear. An HIV positive person can still spread the disease even though he or she may appear healthy.

HEPATITIS (Hepatitis C Virus, Hepatitis B Virus)

Hepatitis is a virus which can be transmitted from individuals through body fluids. The virus is passed on when the blood or body fluids of an infected person mix with your own.

BEHAVIORS THAT INCREASE YOUR RISK OF BEING EXPOSED TO HIV AND OTHER INFECTIOUS DISEASES:

Recent blood, plasma, or blood product transfusion, intravenous drug use, especially with sharing of needles or syringes, or having sexual contact with someone who: has tested positive for HIV, Hepatitis, sexually transmitted infection, is at risk of infection through sexual practices, IV drug use, or recent blood transfusion, uses illicit intravenous drugs, received blood transfusions, plasma, or clotting factor before 1985 or within the last twelve months, has more than one sexual partner, especially ones who could be at risk of HIV, Hepatitis or other sexually transmitted infections.

VOLUNTARY TESTING

The voluntary tests are blood tests testing for the presence of the HIV virus, HBV and other infectious diseases. A positive test result means that you have been exposed to the virus, and either have made antibodies or are infected.

Infectious Disease testing is voluntary, and results are confidential by law. Results can only be given to people you allow, and a release form must be signed prior to releasing this information. The law requires CBBA to report any positive Infectious Disease test results to the Arkansas Department of Health.

CONSENT *(REQUIRED)*

I have read the above information and have had my questions about the Infectious Disease tests answered. I agree to take the Infectious Disease tests. I allow the test results to be made available to CBBA and to my private physician, **Dr**._____.

Printed Full Name of Expectant Mother's: _____ Date: _____

Expectant Mother's Signature (full name as printed above): _____

PHYSICIAN'S ORDER FOR BLOOD TESTING *(REQUIRED)*

Rx Patient Name**:** _____

It is an FDA requirement that CBBA performs maternal blood testing. **Tubes will be included with the cord blood collection kit to be drawn at the hospital/birthing center during labor and delivery.**

ORDER: Maternal Blood Draw for:

HIV-1 and HIV-2 (antibody to the AIDS virus)
HEPATITIS B (HBsAg & HBcAb)
HTLV-I and HTLV-II
CMV,
WNV

HCV/HIV NAT (Hepatitis C and AIDS virus by Nucleic Acid Test)
HEPATITIS C VIRUS (Anti-HCV)
SYPHILIS,
ABO Rh
CHAGAS DISEASE

Printed Name of Physician or Midwife: _____ Date: _____

Signature of Physician or Midwife: _____

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