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## PATIENT EDUCATION AND CONSENT – UMBILICAL CORD STEM CELL COLLECTION

*This form is to insure your understanding about the potential health benefit of Umbilical Cord Blood Banking. The accompanying literature should be reviewed. If you have any questions about cord blood stem cell collection and banking please refer to the brochure given to you.*

I have been provided with information about banking my newborn's umbilical cord blood to help me make an informed choice regarding the preservation of my newborn's stem cells.

- I understand that this program is an elective option to collect and store my newborn's umbilical cord blood. It is my choice to enroll and participate.
- I understand that the program is designed to provide a source of genetically related cord blood stem cells for potential future use and that the birth of my newborn represents the only opportunity to collect them.
- I understand that this program may not be reimbursed by my insurance carrier and may not be covered my Medicare or comparable state programs. I am responsible for the fees.
- I have had all of my questions answered to my satisfaction. I understand the potential implications of cord blood banking for future use by my newborn and family.
- I have chosen to collect and bank my newborn's umbilical cord blood. I accept the responsibility to complete the necessary arrangements for cord blood banking.

I understand there is a Collection **Fee of $350.00 payable to Pablo E. Delgado, MD.,** P.A. before my delivery date. I accept the responsibility for payment to Pablo E. Delgado, M.D., P.A.

______________________________________ ______________________________________

**Patient's Signature** **Date** **Witness' Signature** **Date**

For Caregiver's Use Only:
Patient's Name:______________________ DOB: ________________ Date:____________
Payment Agreement: ________________________________________________________
________________________________________________________________________