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Family Starts with Hope

ADVANCED TREATMENTS. COMPASSIONATE CARE.

At New Hope Fertility Center NYC, success is our first concern. We understand the dream of having a healthy baby and know that the journey to parenthood can be challenging. Our belief is that how you are treated is how we would like to be treated.

Let our family help build yours through unique treatment plans that have been customized to your medical needs. Begin your journey today.
WHO WE ARE:

A true pioneer in the area of minimally invasive (Natural Cycle and Mini-IVF™) fertility care, Dr. John Zhang founded New Hope Fertility Center in 2004, and has since opened locations in China, Russia, and Mexico.

Since opening, Dr. Zhang has been behind several notable achievements in the area of assisted reproductive technology (ART), including the birth of a child by a 49 year-old using her own eggs, helping to restore a young woman’s fertility through a recent ovarian tissue transplant surgery in February of 2012, and being named one of New York’s Top Doctors in 2011.

Dr. Zhang completed his medical degree at the Zhejiang University School of Medicine, and subsequently received his Master’s Degree at Birmingham University in the UK. In 1991, Dr. Zhang earned his Ph.D. in In-Vitro Fertilization (IVF), and, after studying and researching the biology of mammalian reproduction and human embryology for nearly ten years, became the first Fellow in the Division of Reproductive Endocrinology and Infertility of New York University’s School of Medicine in 2001.

Today, Dr. Zhang continues his research in non-embryonic stem cell research, long-term cryopreservation of oocytes, and oocyte (human egg cell) reconstruction by nuclear transfer. He is currently one of a handful of reproductive endocrinologists in the United States to hold a Ph.D. in embryology while also being certified as a high complexity lab director.

Message from Dr. John Zhang:

“The first thing that we do is talk to our patients to understand their unique needs. Then we create a customized fertility care plan. This system has allowed New Hope to have many successes, including breaking the age barrier for women who previously had trouble conceiving.”
WHO WE ARE:

Dr. Yang is board certified in Obstetrics and Gynecology, specializing in minimally invasive procedures with a strong interest in treating patients with PCOS, diminished ovarian reserve, Mini-IVF™, Natural IVF, and uterine lining issues. Since joining New Hope Fertility Center in 2008, he has actively participated in groundbreaking research projects as well as daily clinical procedures. He has been selected as a Top Obstetrician & Gynecologist in the United States since 2009.

Dr. Yang received his MD with high honors from Henan Medical College in 1983, and his Masters and Ph.D. in Toxicology from Tongji Medical University in China in 1986 and 1989. While working in Beijing, Dr. Yang was appointed Associate Director of the Molecular Biology Laboratory at the Institute of Occupational Medicine with the Chinese Academy of Preventive Medicine. He was subsequently appointed as Assistant Professor in the Department of OB/GYN at New York University’s School of Medicine in 1998. He has published more than 30 papers in internationally recognized journals.

Mingxue completed his internship and residency training in Obstetrics & Gynecology at NYU’s School of Medicine and the New York Downtown Hospital. Upon graduating, he was appointed as teaching attending in the Department of OB/GYN at New York Downtown Hospital affiliated with New York-Presbyterian Healthcare System and Weill Cornell Medical College. He received the National Faculty Award for Excellence in Resident Education in 2006 by the Council on Resident Education in Obstetrics and Gynecology. In 2005, he also received an award for Special Excellence in Endoscopic Procedures by the American Association of Gynecologic Laparoscopists.

Message from Dr. Mingxue Yang:

“In my last four years with New Hope, I’ve done more than 2000 procedures involving embryo transfers. With a background in internal medicine, I’ve instilled this experience into our treatments, which complement the mind, body, and health history of each patient.”
Dr. Zitao Liu is an accomplished physician with a deep understanding of the field of assisted reproduction technology (ART). He received his medical degree from the Norman Bethune University of Medical Sciences in China, then went on to earn his PhD from Wayne State University, studying pre-implantation embryonic development and completed his post-doctoral research on uterine responses to embryo implantation at Vanderbilt University. He completed his residency training in Obstetrics and Gynecology at Bronx-Lebanon Hospital Center, an affiliate of the Albert Einstein College of Medicine and, before joining New Hope Fertility Center, he practiced academic medicine as an attending physician in the Department of Obstetrics and Gynecology at Tufts Medical Center.

Dr. Liu has received many teaching awards from the Albert Einstein College of Medicine, the Tufts University School of Medicine, and the American College of Obstetricians and Gynecologists. Years of clinical practice and academic research have shown Dr. Liu the limitations of conventional IVF. He is not only a strong advocate of minimal stimulation IVF protocols (Natural IVF and Mini-IVFTM) for indicated patients, but is an accomplished surgeon for minimally invasive procedures as well.

Dr. Liu still actively continues his clinical research in embryo implantation and trophoblast differentiation. At the same time, he is constantly pursuing the development of new medical devices, novel medications, and advanced diagnostic approaches.

Message from Dr. Zitao Liu:

“I would like to integrate the results of the cutting-edge research into clinical practice and find the best protocol for each individual woman I work with.”
Dr. Merhi joins New Hope Fertility Center as the Director of Research and Development in IVF Technologies. His research also focuses on obesity-related infertility, Polycystic Ovary Syndrome (PCOS), Minimal Stimulation IVF (Mini IVF), Natural IVF for women with low ovarian reserve and GNRH analog ovulation triggering.

Dr. Merhi attained his Bachelor of Science degree in Biology and a medical degree from the American University of Beirut in Lebanon. He completed his residency in Obstetrics and Gynecology at Maimonides Medical Center in Brooklyn, New York after which he did a two-year Postdoctoral Fellowship in Reproductive Endocrinology at Albert Einstein College of Medicine in Bronx, New York. Subsequently, he completed a three-year Clinical Fellowship in Reproductive Endocrinology and Infertility at Albert Einstein College of Medicine/Montefiore Medical Center in Bronx, New York.

Board-certified in Reproductive Endocrinology and Infertility by the American Board of Obstetrics and Gynecology, Dr. Merhi was an Assistant Professor in Reproductive Endocrinology and Infertility at the University of Vermont College of Medicine in Burlington and most recently, an Assistant Professor of Obstetrics and Gynecology and Reproductive Biology at NYU School of Medicine in New York City.

As an active researcher and honoree of many awards, Dr. Merhi has published over 60 manuscripts in respected medical journals such as Journal of Clinical Endocrinology and Metabolism, Fertility and Sterility, and Human Reproduction, as well as many book chapters. He continues to present his research at national and international scientific conferences. Various media outlets have reported on his research including ABC News, Medscape, and dietsinreview.com. His scientific interests are focused in the area of Low Ovarian Reserve, PCOS, and Obesity-Related Infertility.

Dr. Merhi serves as a Chair, Moderator, Reviewer, and Member on several committees such as American Society for Reproductive Medicine (ASRM), New England Fertility Society, Society for Reproductive Investigation, and Endocrine Society. He has also served as a grant reviewer for the National Institute of Health (NIH). He evaluates, edits, and reviews manuscripts for over 30 scientific journals. Dr. Merhi uses his extensive research background to provide the most up-to-date medical advances in infertility treatments.

Dr. Merhi Speaks English, Arabic, French and Spanish.

“I look to form a personal relationship with patients to establish confidence and provide superior fertility and endocrinology care.”
Dr. Jennifer Kulp-Makarov is board-certified in both OB/GYN and Reproductive Endocrinology & Infertility. She has years of experience treating women and couples with infertility. She graduated cum laude from Tufts University with a BS in biology and was awarded her medical degree from UMDNJ – Robert Wood Johnson Medical School. She completed her OB/GYN residency at Johns Hopkins Hospital and a fellowship in Reproductive Endocrinology and Infertility at Yale University School of Medicine.

She has a special interest in helping couples conceive using both basic and advanced reproductive technologies. The services she offers include diagnosing infertility and recurrent pregnancy loss, Intrauterine Insemination (IUI), donor sperm insemination, in vitro fertilization (IVF) including Mini IVF and Natural IVF, egg donation and genetic testing of embryos. She also sees women desiring fertility preservation and egg freezing. In addition, Dr. Makarov works closely with the LGBT community and has helped many single women and same sex couples to start or grow their families.

Dr. Makarov offers individually tailored treatment protocols for women with decreased ovarian reserve. She specializes in personalized treatment of infertility and has extensive experience in treating women with difficult cases of infertility including multiple failed IVF cycles. Her expertise in Mini and Natural IVF cycles allows for a more natural and gentle approach to fertility care.

Dr. Makarov is committed to helping people start or complete their families. She firmly believes in providing personalized, patient-centered and compassionate care to each individual seeking to become a parent.

“Listening to the body and utilizing its naturally occurring fertility cycle allows us to work with your body to more effectively achieve pregnancy.”
Dr. Lana Lipkin is proud to be part of New Hope Fertility Center’s top fertility doctors in NYC and has a focus on female infertility in particular Polycystic Ovary Syndrome (PCOS), hysteroscopy, and laparoscopy procedures. She also specializes in Family Balancing to ensure each couple has the family of their dreams. She is Board certified by the American Board of Obstetrics and Gynecology (ABOG) with over 10 years of experience providing compassionate reproductive care to patients in the New York City metro area.

Dr. Lipkin completed her residency training in North Shore’s Manhasset Campus (now called Northwell Health) before joining Columbia University’s faculty at the Allen Hospital as a Clinical Assistant Professor in Obstetrics and Gynecology. Over her 7-year career at Columbia University, Dr. Lipkin received multiple teaching awards. She is highly rated online by her patients. She is an active member of the American Congress of Obstetricians and Gynecologists (ACOG) and the American Association of Laparoscopic Surgeons (AAGL).

With a genuine interest in helping patients realize their dreams of building a family, Dr. Lipkin specializes in treating patients with advanced maternal age-related infertility (AMA), and patients with low ovarian reserve or poor egg quality. Her dedication to making a difference in people’s lives is what led her to the practice of medicine; her decision to specialize in fertility revolves around the personal nature of her practice.

She has written extensively on fertility topics including authoring the preeminent Atlas of Hysteroscopy which is currently available online. She is also a major contributing medical writer for Board Eligibility test preparation.

In her spare time, Dr. Lipkin recently rediscovered her passion for lyrical dance, specifically Jazz, Modern, and Ballet. She was born in Belarus and she currently resides in New Jersey and, in addition to English, she speaks fluent Spanish, Hebrew, and Russian.

“Every patient is unique, as are their reproductive goals, and should be addressed on an individualized basis.”
Patients come first at New Hope. We strive to provide the best fertility care, from maintaining the highest medical, scientific and academic standards, to supporting every stage of the journey to parenthood.

One of the most important things to know about New Hope Fertility care is that we custom design our fertility treatments to the individual. Each person’s unique protocol is specially designed to ensure the patient is receiving the highest quality care at the most optimal times for their body. We achieve this through blood testing and constant monitoring.

Our treatments at New Hope offer minimal stimulation and result in a gentler and more physiologically supportive experience. With a Conventional IVF cycle, numerous shots and medications simultaneously shut down the body’s naturally occurring fertility system and create an artificial one, forcing the ovaries to create many eggs. Our Mini-IVF™ and Natural Cycle IVF protocols allow us to learn about your body so that we can help you augment and enhance your own, naturally occurring fertility.

New Hope diligently monitors and adjusts treatment protocols to nurture your body’s highest quality eggs, allowing for high success rates with Single Embryo Transfer. Our advanced technique for cryopreservation (vitrification) has over 90% thaw-survival-rate, providing you the option to freeze additional embryos.
WHY CHOOSE NEW HOPE?

10+ years of experience

500+ babies born from eggs frozen since 2004

4500+ cycles done in 2014

EGG FREEZING SURVIVAL RATE

90%

Using Vitrification

VITRIFICATION is method of FLASH FREEZING that prevents the formation of ice crystals within an egg

High Success Rate

MINI-IVF™

62.5%

Live Birth Rate
1100 embryos transferred in 2014

NATURAL CYCLE IVF

70%

Average 1.2 embryos transferred per cycle

aCGH/PGS

70%

over 40% non-aCGH/PGS cycles
A small sample of cells are removed from the outside layer of a blastocyst embryo. The cells that have been removed from each embryo are loaded into a small tube and sent to the reference laboratory for Next Generation Sequencing. The cells are analyzed to verify that all 23 sets of chromosome pairs are identified to confirm the embryo is genetically normal.

Based on the genetic results, you and your medical team will select which embryo will be transferred.

**What is NGS?**

Next Generation Sequencing or NGS is a form of preimplantation genetic screening that can be performed on embryos.
- Ensures 23 pairs of genetic chromosomes are present
- Ensures no aneuploidy is occurring
- Detects mosaicism (fragmented chromosomes)

**NGS Benefits**

- Reduce chance of miscarriage
- Reduce # of IVF cycles
- Reduce risk of multiple pregnancy
- Increased live birth rates
- Increased ongoing pregnancy rates

**IVF Timeline for PGS/NGS**

<table>
<thead>
<tr>
<th>Day</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0</td>
<td>ER Retrieval &amp; Insemination</td>
</tr>
<tr>
<td>D1</td>
<td>Fertilization</td>
</tr>
<tr>
<td>D2</td>
<td>2-4 Cells</td>
</tr>
<tr>
<td>D3</td>
<td>6-8 Cells</td>
</tr>
<tr>
<td>D4</td>
<td>Biopsy Preparation Begins (Assisted Hatching)</td>
</tr>
<tr>
<td>D5</td>
<td>Biopsy Process &amp; Blastocyst Freezing Occurs</td>
</tr>
<tr>
<td>D6</td>
<td>Confirmation of sending biopsy samples out for testing</td>
</tr>
<tr>
<td>D7</td>
<td>PGS Test Results</td>
</tr>
<tr>
<td></td>
<td>Completion of IVF Cycle</td>
</tr>
<tr>
<td></td>
<td>Frozen Embryo Transfer (FET) Cycle preparation</td>
</tr>
</tbody>
</table>

**% Normal Embryo by Age Group**

<table>
<thead>
<tr>
<th>Age</th>
<th>% Normal Blastocyst</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;35 years</td>
<td>48%</td>
</tr>
<tr>
<td>35-37 years</td>
<td>44%</td>
</tr>
<tr>
<td>38-40 years</td>
<td>33%</td>
</tr>
<tr>
<td>41-42 years</td>
<td>17%</td>
</tr>
<tr>
<td>&gt;42 years</td>
<td>11%</td>
</tr>
<tr>
<td>Egg Donors</td>
<td>61%</td>
</tr>
</tbody>
</table>

*Provided statistics reflect national averages and not guaranteed clinic results.

For more information please contact us:
Email: embryology@nhfc.com
Phone: (212) 969-7430
4 Columbus Circle, 4th Floor
New York, NY 10012

www.newhopefertility.com
In-Vitro Fertilization:

**Mini-IVF™**

Mini-IVF™ treatment is our trademarked minimal stimulation in vitro fertilization protocol. Like our Natural Cycle IVF, it is a holistic approach to fertility care and offers a gentle alternative to Conventional IVF. It differs from Natural Cycle IVF in its use of a minimal amount of oral medication which stimulates the ovaries so they produce the maximum number of “quality” eggs in a single cycle.

Mini-IVF™ minimizes the amount of chemicals and drugs used in fertility treatment. Mini-IVF™ may increase the chances of pregnancy and may provide surplus embryos to freeze for a later cycle.

**Ultra Mini-IVF™**

An evolution on mini-IVF, Ultra, Mini IVF uses only oral stimulation medication, usually 1-2 pills/day

**Natural Cycle IVF**

Rather than stimulating your ovaries to produce multiple eggs, Natural Cycle IVF is intended to capture the one egg that your body naturally produces each month during your menstrual cycle. This egg is generally not only the best quality but will also give you the greatest chance for pregnancy.

Natural Cycle IVF is ideal for women who prefer fewer drugs and medications, for older women, or for women who are less likely to produce multiple eggs even with the administration of IVF drugs. Natural Cycle IVF can allow women in these groups to avoid the health risks and high cost of IVF drugs as well as the discomfort of daily injections.

**Conventional IVF**

The conventional hyperstimulation IVF treatment relies on daily injections of IVF hormone drugs to stimulate the ovaries to produce the maximum number of eggs possible in each cycle. All eggs are targeted for stimulation regardless of quality, which means this fertility treatment method produces a surfeit of eggs, many of which are not viable. Thus, hyperstimulation generally produces three to five “quality” eggs viable for a sustainable pregnancy, much like our Mini-IVF™ treatment.
PROCEDURES/
LIST OF SERVICES

NATURAL IVF

NO MEDICATION

--- BLOOD TEST & SONOGRAM DAY ---

DAY 3 DAY 8 DAY 10 DAY 12 DAY 14

--- NEXT CYCLE ---

EGG RETRIEVAL LOCAL ANESTHESIA

ICSI/IVF

HCG INJECTION
(for ovulation induction)

EGG RETRIEVAL LOCAL ANESTHESIA

DAY 16

DAY 19

ULTRA MINI-IVF™

CLOMIPHENE CITRATE (CLomid)
AND/OR LETRAZOLE (FEMARA)

--- BLOOD TEST & SONOGRAM DAY ---

DAY 3 DAY 8 DAY 10 DAY 12 DAY 14

--- NEXT CYCLE ---

TRIGGER INJECTION
(for ovulation induction)

EGG RETRIEVAL LOCAL ANESTHESIA

ICSI/IVF

BLASTOCYST CRYOPRESERVATION

FROZEN EMBRYO TRANSFER

MINI-IVF™

CLOMIPHENE CITRATE
(CLOMID)

--- BLOOD TEST & SONOGRAM DAY ---

DAY 3 DAY 8 DAY 10 DAY 12 DAY 14

--- NEXT CYCLE ---

TRIGGER INJECTION
(for ovulation induction)

EGG RETRIEVAL LOCAL ANESTHESIA

ICSI/IVF

BLASTOCYST CRYOPRESERVATION

FROZEN EMBRYO TRANSFER

CONVENTIONAL IVF

DAILY Lupron INJECTIONS & DAILY GONADOTROPIN INJECTIONS

--- BLOOD TEST & SONOGRAM DAY ---

DAY 3

--- NEXT CYCLE ---

HCG INJECTION
(for ovulation induction)

EGG RETRIEVAL IV SEDATION

ICSI/IVF

EMBRYO TRANSFER

DAY 16

DAY 19
List of all our procedures:

- Egg Donation
- Egg Freezing with Vitrification
- Conventional IVF (In Vitro Fertilization)
- Mini IVF
- Natural IVF
- In Vitro Maturation (IVM)
- Intrauterine Insemination (IUI)
- Intracytoplasmic Sperm Injection (ICSI)
- Male Fertility Care
- Hysteroscopy
- Fertility Evaluation
- Fertility History
- Physical Exam
- Blood Testing
- STDs
- Semen Analysis
- Sperm Aspiration for ICSI
- Testicular Sperm Aspiration
- Testicular Biopsy
- Microsurgical Epididymal Sperm Aspiration (MESA)
- Testicular Sperm Extraction (TESE)
- Submucous Resection of Fibroids
- Ovary Transplantation
- Laparoscopy
- Tubal Cannulation
- Gynecologic Laser Surgery
- Laparoscopic Myomectomy

Specialties

- PCOS
- Low Ovarian Reserve
- Endometriosis
- Multiple Miscarriage
- Poor Responder
- High FSH
- LGBT Couples
- Ovarian Cyst
- Cancer Related Infertility
- Unexplained Infertility

Insurances accepted—call for updated list

- Aetna • GHI • HIP Prime • Emblem • Empire Blue Cross Blue Shield • United Health Care
- United Health Care Empire Plan • Oxford • Cigna • 1199 • PHCS • GMMI • Nippon
IN THE NEWS

TIME

The New York Times

CCTV

The Wall Street Journal

NEW YORK POST

IN THE NEWS:

CNN

The Huffington Post

NTD

PIX11

People

ED

BAZAAR

GLAMOUR

Elite Daily

in touch

ARISE NEWS

metro

DAILY NEWS

BBC
Baby Steps

At Fertility Clinics, A New Emphasis On Gentle Methods
Harvesting Fewer Eggs Puts Less Stress on Patients; Does It Cut Success Rate?
Ms. Piragas Has a Scare
By SYLVIA PÁGAN WESTPHAL
March 23, 2006; Page A1

Nichola Grant underwent five in-vitro fertilization attempts the traditional way. First came weeks of daily hormone shots to stimulate egg production, which painfully bloated her ovaries and stomach. Then doctors inserted a needle through her vaginal wall to remove the eggs -- up to 20 at a time, she says -- from her ovaries. On three occasions fertilized eggs were put back in her womb but failed to lead to a baby.

That was enough discomfort for Ms. Grant, a 34-year-old nurse in Queens, N.Y. She went to Manhattan fertility doctor John Zhang. There were barely any shots -- mostly pills -- and he removed just three eggs. He implanted one in the womb, and she delivered a baby boy in January. "It was so easy," she says. "It's no comparison."

Dr. Zhang doesn't claim his method leads to higher pregnancy rates, but he does assert that Ms. Grant's story represents what's wrong with standard operating procedure at fertility clinics. He says the fertility profession is too concerned with drawing lots of eggs from women. The result, he believes, is more pain, a higher risk of complications and a success rate little improved over gentler approaches.

The Zhang method and others like it, while supported only by preliminary evidence, are fueling debate in a fast-growing business. Women in the U.S. underwent more than 120,000 in-vitro fertilization procedures in 2003, nearly double the figure in 1996, according to federal-government data. Americans spend nearly $3 billion a year on IVF, according to Debora Spar, a Harvard Business School professor who studies the fertility industry.

"If you take too much fertility drugs, you make too many useless eggs," says Dr. Zhang, a native of China who completed his residency at the New York University School of Medicine.

"A lot of people realize we're overdoing it," adds George Inge, a doctor at the Center for Reproductive Medicine in Mobile, Ala. "We've got to come out with ways so women are not so beat down."
in the news:

Time Magazine
June 10, 2013
“Frontiers of Fertility”
Making Babies Ought to Be the Easiest Thing You'll Ever Do—Indeed, it Ought to Be a Hard Thing Not to Do. The Evolutionary Game Is Rigged So That It's Fun, the Kind of Fun You Want to Have Even When Offspring Aren't on Your Mind. Our Body Cycles Make Parenthood a Constant Possibility; Women Are Ready to Conceive Every Month, and Men Are Pretty Much Ready to Go Any Second. And the Product of All That Happy Activity—a Chubby, Cuddly, Coiling Baby—is Something We're Hardwired to Find Irresistible.

But Things, of Course, Aren't Always So Simple. The Human Reproductive System May Be a Prolific Thing, But It's Also a Very Fragile Thing, and There Is a Lot That Can Go Wrong with It. In the U.S. Alone, More Than 7 Million Women Have Received Treatment for Infertility, Spending More than an Estimated 15 Billion Per Year. For the Past 20 Years, the Average Billed Cost for a Single In Vitro Fertilization (IVF) Cycle Is $12,000—Something Infertile Couples Must Pony Up On Their Own Since Most Insurance Companies Don't Cover Infertility Treatments—and Just One Cycle Is Usually Not Enough. According to the U.S. Centers for Disease Control and Prevention, Only 14% of Assisted-Reproduction Cycles Lead to a Live Birth When the Woman Is Younger than 35. The Figure Drops to 12% by Age 40, 12% by 42 and Just 5% by 44. Outside the U.S., the Odds Are No Better, and the Number of People Who Need Help Is Far Greater; An Estimated 48.3 Million Couples Worldwide Are Unable to Conceive After Five Years of Trying, According to Figures Released Last Year by the World Health Organization.

Given the Powerful, Primal Hold Baby-Making Has on Us, the Inability to Perform So Straightforward a Genetic Job Can Be Deeply Painful. "My Husband and I Would Look Around, and Everyone We Knew Was Having Kids," Says Cindy Flynn, 35, an IT Worker at a Sacramento Nonprofit. "We Struggled So Hard To Get Pregnant. Building a Family Should Not Be So Difficult."

For Now, It Still Is, But the Outlook Is Getting Decidedly Brighter. Scientists Are Steadily Refining and Improving Assisted-Reproduction Techniques. They're Harvesting Better Eggs, Using Fewer Drugs to Do It and Selecting More Vigorous Sperm That Have a Better Chance of Producing a Baby. They're Monitoring Embryos While They're Still in Experimental. Today I Can Often Say, There Is at Least a 2 Out of 3 Chance You Are Going to Have a Baby Out of This Process. It Is Becoming the Most Exciting Field, With the Most Gratifying Outcomes You Can Imagine.

Boosting the Odds Improving the Outlook for Fertility Patients Starts with Improving the Art of IVF, Which Is Not Just Expensive and Less Than Reliable But Also True Physical Grind. Women Must First Endure a Month's Worth of Hormonal Dosings, Including Two or Three Shots a Day in the Final Stretch, All of Which Can Lead to Headaches, Restlessness, Irritability and Hot Flushing. The Dosings Pushes the Ovaries to Hyperovulate, Producing Up to a Dozen Ova at Once, Which Are Retrieved Via Laparoscopy Through an Incision in the Pelvis. Even After...

BABY'S FIRST PICTURES Time-lapse images like these can help identify which embryos are the most viable

7 million women have received treatment for infertility, spending more than an estimated 15 billion per year. For the past 20 years, the average billed cost for a single in vitro fertilization (IVF) cycle is $12,000—something infertile couples must pony up on their own since most insurance companies don't cover infertility treatments—and just one cycle is usually not enough. According to the U.S. Centers for Disease Control and Prevention, only 14% of assisted-reproduction cycles lead to a live birth when the woman is younger than 35. The figure drops to 12% by age 40, 12% by 42 and just 5% by 44. Outside the U.S., the odds are no better, and the number of people who need help is far greater; an estimated 48.3 million couples worldwide are unable to conceive after five years of trying, according to figures released last year by the World Health Organization.

Given the powerful, primal hold baby-making has on us, the inability to perform so straightforward a genetic job can be deeply painful. "My husband and I would look around, and everyone we knew was having kids," says Cindy Flynn, 35, an IT worker at a Sacramento nonprofit. "We struggled so hard to get pregnant. Building a family should not be so difficult."

For now, it still is, but the outlook is getting decidedly brighter. Scientists are steadily refining and improving assisted-reproduction techniques. They're harvesting better eggs, using fewer drugs to do it and selecting more vigorous sperm that have a better chance of producing a baby. They're monitoring embryos while they're still in experimental. Today I can often say, there is at least a 2 out of 3 chance you are going to have a baby out of this process. It is becoming the most exciting field, with the most gratifying outcomes you can imagine.

Boosting the Odds

Improving the Outlook for Fertility patients starts with improving the art of IVF, which is not just expensive and less than reliable but also a true physical grind. Women must first endure a month's worth of hormonal dosings, including two or three shots a day in the final stretch, all of which can lead to headaches, restlessness, irritability and hot flushing. The dosings pushes the ovaries to hyperovulate, producing up to a dozen ova at once, which are retrieved via laparoscopy through an incision in the pelvis. Even after...
tail,” says Niederberger, “and there’s a lot you can find that looks wrong. You would think if you can find the best-looking sperm, it would also be the healthiest one, but that is absolutely not correct. The vast majority of sperm—up to 95%—look abnormal, and the exact shape of a sperm doesn’t necessarily equate to its success.”

This is increasingly problematic as doctors turn away from the original IVF method of simply mixing an egg and a semen sample in a dish and adopt a more exacting approach known as intracytoplasmic sperm injection (ICSI), in which a single, especially handsome sperm is selected, lifted by the tail and injected directly into the egg. That practically guarantees fertilization, but if the technician was fooled by looks and rejected more viable candidates—what fertility experts dub “overcalling” sperm—it may doom a pregnancy before it can even get started.

All of this explains the growing interest in an approach called mini IVF, which Zhang’s and other clinics are promoting. As its name suggests, mini IVF strips the familiar in vitro regimen down to a way that makes it both less arduous and, its proponents say, more effective. Rather than endure a month of hormonal carpet bombing, women take a 12-day course of Clomid, an oral drug that blocks the body’s estrogen receptors and promotes egg maturation. This causes the ovaries to produce only three to five comparatively viable eggs rather than the dozen often immature ones. In the final day or two of the cycle, the women also use a nasal-spray version of Serostim, a drug that’s usually used to treat endometriosis but in this case helps trigger egg release. Eggs are then retrieved and fertilized as in traditional IVF.

“The physiologic changes the body experiences in mini IVF are close to the natural cycle, with fewer drugs,” says Zhang. Starting with fewer embryos can also help mitigate the ethical issues raised when unused ones are frozen and stored in clinics, with little or no prospect of ever being implanted but little or no appetite on the part of anyone involved to destroy them.

Not everyone is sold on the promise of mini IVF. Some critics suggest that the odds of producing a successful pregnancy with mini IVF are actually lower than with traditional IVF, but so far there have and to do that without destroying them in the process. One method is to use something called Raman spectroscopy, which involves beaming laser energy of a particular frequency at the head of the sperm; the beam scatters back in readable patterns that reveal clues to the interior structure. The technique isn’t quite ready for wide use, but it’s getting close. “People are studying various frequencies along the electromagnetic spectrum to interrogate the sperm in a nondestructive way,” says Niederberger. “This holds a lot of promise.”

Even assuming the very best sperm can be matched with the very best egg, doctors still have to determine which of the several embryos that are often created in any one IVF cycle is the most viable one to transfer to the womb. That remains a highly subjective matter that depends, again, simply on which one looks the best. “Identifying the single best embryo for implantation is one of the challenges of the last decades in assisted reproduction,” says Dr. Zev Rosenwaks, director of the Center for Reproductive Medicine at New York-Presbyterian Hospital/Weill Cornell Medical Center.

At Rosenwaks’s clinic, doctors are addressing that challenge with a time-lapse photography system that snap pictures of growing embryos every 10 to 20 minutes for the first few days of incubation. Subtle differences in the way they divide can provide clues to which embryos are the strongest. Similar techniques were tried in the past, but the pictures were taken manually by lab technicians, which required opening the incubator...
A NEW APPROACH TO IVF

In vitro fertilization is an ordeal that often does not produce a baby. Mini IVF involves fewer shots—and may be more effective.

Conventional IVF
- Daily injections of gonadotropin-releasing hormone, which allows multiple eggs to mature at the same time
- Injection of human choronic gonadotropin to help mature eggs
- Eggs retrieved using a catheter
- Fertilization
- Embryos are frozen or transferred to uterus

Mini IVF
- Daily Copid tablet to help eggs mature in the ovary, with a few injections of gonadotropin-releasing hormone
- Dose of Synarel nasal spray to release eggs from ovary
- Eggs retrieved using a catheter
- Fertilization
- Embryos are frozen or transferred to uterus

Day 21 (previous menstrual cycle)
- Day 5
- Day 8
- Day 10
- Day 12
- Day 14
- Day 16
- Day 19 (next cycle)

Day 2
- Day 3
- Day 4
- Day 5
- Day 6
- Day 7
- Day 8
- Day 9
- Day 10
- Day 11
- Day 12
- Day 13
- Day 14
- Day 15
- Day 16
- Day 17
- Day 18
- Day 19
- Day 20
- Day 21
- Day 22
- Day 23
- Day 24
- Day 25
- Day 26
- Day 27
- Day 28

In the News:

Several times a day, exposing the embryos to blasts of room temperature air and contaminants. The new cameras peer through glass into the sealed incubator and fire off their pictures automatically. “We have increased pregnancy rates across the board while decreasing the likelihood of a birth,” says Rosenwaks. “Whether the woman is younger or older, in every category we have improved pregnancy rates by 15% to 20%.”

This process too faces some early challenges—principally ones of access. There are more than 400 fertility clinics in the U.S., but only a few dozen so far have a system like Rosenwaks’. Not only does that exclude an overwhelming share of patients; it also means the 15%-to-20% improvement rate could be a premature boast, depending on how other clinics fare if they adopt the new technology.

Further out on the developmental frontier are stem cells. For decades it was assumed that girls are born with all the eggs they will ever have and can produce no more during their lives. In 2012 that wisdom was overturned when Jonathan Tilly, director of reproductive biology at Massachusetts General Hospital, announced that the ovaries harbor stem cells that, with the right chemical coaxing, could be made to mature into eggs.

Tilly accomplished that egg-growing feat—after a fashion—by harvesting stem cells from ovaries removed during sex-reassignment surgery, growing them in a dish, repackaging them in a bit of the original ovarian tissue and transplanting the entire little bundle into a lab mouse so that it would receive a steady blood supply. (Implanting it in a woman would have raised ethical issues.) When Tilly extracted the eggs, they had indeed matured into what at least appeared to be fully mature ova.

Not even Tilly pretends that his method is safe or practical—at least not yet—but as a proof-of-concept study, it shows promise. The threshold requirement for parents conceiving via IVF, after all, is at least one healthy sperm meeting one healthy egg. If you don’t have that, all the improvements in the world in embryo monitoring and implantation do you no good.

Investigators at Newcastle University in England had similar success on the male side of the equation in 2009, using embryonic stem cells to create living, swimming, healthy-looking sperm—though the researchers have no idea if the sperm are viable, and British law prevents them from attempting fertilization and implantation to find out for sure. Since then, they have been working on ways to sidestep the use of embryonic stem cells and all the ethical issues they raise by creating stem cells from the skin cells of the infertile men, which could then develop into sperm.

Expanding the Choices?

The more the medical options expand, the more some doctors—and couples—wrestle with the implications. Fertility counselors, when framing patients’ choices, remind them that they can continue to try to conceive or they can choose to adopt or live child-free. That’s a word that’s clearly chosen with the intention of replacing the bleaker-sounding childless and capturing the notion of an upside for a loving couple living a free and relatively unencumbered life.

For those who decide to turn to science to boost their fertility, cost is a small issue. Assisted reproduction remains expensive and is typically not covered by insurance. Under the Affordable Care Act—a.k.a. Obamacare—basic gynecologic and obstetric care are covered, but infertility treatment isn’t. The law does increase the available deduction for those treatments from 75% of pretax income to 10%. (For people who adopt, there is a tax credit of $17,060.)

In a perfect world, money wouldn’t stand in the way of having a child, but in a perfect world, neither would infertility problems. Basic sex the reproductive drive might be, a lot of things have to go just right for a healthy baby to be the result. For a growing number of parents-in-waiting, more is starting to go right than wrong. —WITH REPORTING BY ALEXANDRA SIFFERLIN/NEW YORK
47-year-old woman gives birth to twins
By Melissa Klein and Kate Briquelet
MAY 11, 2014

Doctors said she was too old to have a baby. Now she's celebrating Mother's Day with twins.

Freddi Baranoff, 48, of Brooklyn spent years trying to conceive — and got the surprise of a lifetime when she discovered she was having not one, but two baby girls.

"I was in it for the long haul," said Baranoff, who lives with her husband, Eddie, and five children in Midwood. "However long it took, I was not going to give up."

She's one of many women having children later in life, as the average age for new moms soars, especially in New York.

Statistics from the Centers for Disease Control and Prevention last week show the rate of women having their first child between the ages of 40 and 44 has more than doubled from 1990 to 2012.

New York state ranked first in the nation for the number of moms having their first baby at ages 40 to 44. It was third for women 35 to 39.

About 2.3 in 1,000 women ages 40 to 44 had their first child in 2012, up from 0.4 in 1,000 in 1970. For women 35 to 39, it’s gone from 2.1 to 11 in 1,000.

Still, Baranoff says the journey to having identical twins Elly and Emily, now 18 months old, wasn’t easy.

Once a Midtown trader, she got married at age 31 and had three children, the last born when she was 38.

"I wanted a fourth kid, but didn’t think it was going to be so difficult," she said. “Lo and behold, I found myself in my 40s, and it wasn’t panning out.”

Baranoff said she saw three top fertility specialists, who pressured her to use donor eggs and medications.

"None of them were optimistic," she said. “They basically told me it was a long shot. I was already 45, and one doctor said, 'If you are 45, we shouldn’t even be having this discussion.'”

But she wouldn’t give up. She signed up for acupuncture, hypnotherapy and a healthier diet. She tried relaxation techniques and chamomile teas.

Then she found Dr. John Zhang at the New Hope Fertility Center, a Columbus Circle clinic known for helping women in the 40s conceive without high-cost medications.

Zhang suggested "natural cycle" in-vitro fertilization, which uses a naturally produced egg instead of eggs created with the help of drugs.

For Baranoff, the third egg was the charm. She delivered the healthy girls at age 47.

Baranoff says the twins keep her young while she’s also caring for daughter Prissy, 11, and sons Nate, 14, and Michael, 16. She also has stepsons Joe, 22, and Robert, 25.

“All children are miracles,” Baranoff said, “but once you reach your 40s, you question whether it’s going to happen for you. Don’t give up.

“I’m beyond thrilled,” she added. “This has completed my family.”

The embryos are safe. So are the frozen eggs and sperm at the NYU Fertility Center. But saving them required dramatic effort on the part of hospital workers, as Hurricane Sandy took down power and the backup generator failed.

“There were heroes here,” Dr. Jamie Grifo, the fertility center’s program director said in an interview today, describing the scramble Monday night and Tuesday.

The building that houses the Fertility Center is located at 38th Street and First Avenue, which is outside the flood zone. But by Monday evening the power had failed, the basement had filled with water, and the fire department warned they needed to shut down the generator because they feared it was a fire hazard. The staff at the center offered to pump out the water in order to keep the generator functioning, and did so through the night.

Anything frozen, Grifo explained, was never in danger. When sperm, eggs and embryos are stored for later use, they are frozen in liquid nitrogen, which does not depend on a power source. The real risk was to the live incubated embryos, which are created from eggs retrieved from ovaries, mixed with sperm, grown to a specific number of cells, and returned to the uterus, in a complex and carefully timed process.

At 6 AM Tuesday morning Grifo picked up several staff members and drove to the office. They were there prepping for the day when the lights went out, and they quickly diagnosed that the generator, which was on the roof, had run out of fuel. The pump providing that fuel, which was in the basement, had blown a fuse. The alarm system for that pump did not fail, but the alerts it sent, by phone and internet, went unheard because the NYU system was down.

So the staff switched to the third level of backup, battery packs in the lab designed to keep the incubators working in the event of a generator failure. There were only six hours of power in those batteries, and if the generator could not be restarted by then -- a complicated process that involved refilling the reservoir, changing the fuel filters and jump starting the engine -- the embryos would lose their life support.

Meanwhile a patient had arrived for a scheduled egg retrieval. A phone call was made to Reproductive Medicine Associates of New York, which is the IVF program at Mount Sinai, and Dr. Alan Copperman agreed to take that patient immediately. Dr. Grifo got his car and drove the patient, her husband and their baby -- who had been conceived via Grifo’s lab -- 60 blocks north to Mount Sinai.

Meanwhile, racing the clock, his staff began freezing the incubated embryos in liquid nitrogen. The half dozen patients who had planned to have those embryos transferred this week will have to wait a month, Grifo said, which certainly adds emotional stress to a process that involved refilling the reservoir, changing the fuel filters and jump starting the engine -- the embryos would lose their life support.

The generator was restarted and has functioned continuously ever since. Once full power returns to the building, the incubators are waiting. Until then patients are being seen at a variety of offices around the city, particularly the New Hope Fertility Center in Columbus Circle, which has lent Grifo space, and where he did 11 egg retrievals yesterday, two today and has one scheduled tomorrow.

He received offers of help from around the country, he said, a testament to the fact that “the people in this field understand that there is a patient at the end of this. Everybody is working together not to compromise patient cycles.”

He looks forward to welcoming the babies that he hopes will be born as a result of their work during these chaotic days. Perhaps one of them will be named Sandy.

Every year, the United States Centers for Disease Control (CDC) collects IVF cycle data and publishes the Assisted Reproductive Technology (ART) Success Rates Report. The report is available online at cdc.gov. The most recent report, covering 2014 statistics, was released this week.

Some people like the way the CDC presents the data and some people don’t. Luckily, the CDC makes the raw data available through the website in the form of an Excel spreadsheet, which gives those of us who spend more time than they should looking at rows and columns and writing macros one more excuse to neglect their families and not expose themselves to sunshine.

By isolating columns, using simple sort commands, adding columns and writing simple formulas, we can pull some helpful information out of the CDC data. Not perfect information—clinics don’t reveal their patient selection criteria, for example (some clinics are known for taking on tough cases that other clinics turn away) and can inflate their pregnancy success statistics by doing so, but a good start for patients deciding where to seek treatment. I learned during my years as a reproductive endocrinologist not to underestimate the sophistication of my patients.

I just got my hands on the data yesterday, so I’ll start with a simple question: Which are the busiest IVF clinics in the United States? The busiest 50 are listed below. Much more to come. (Note: when looking at the table below you may need to widen your browser window to see all columns.)

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Location</th>
<th>Cycles</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHADY GROVE FERTILITY REPRODUCTIVE SCIENCE CENTER</td>
<td>MARYLAND</td>
<td>7,648</td>
</tr>
<tr>
<td>NEW HOPE FERTILITY CENTER – WEST SIDE</td>
<td>NEW YORK</td>
<td>5,482</td>
</tr>
<tr>
<td>REPRODUCTIVE MEDICINE ASSOCIATES OF NEW JERSEY</td>
<td>NEW JERSEY</td>
<td>4,975</td>
</tr>
<tr>
<td>WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY</td>
<td>NEW YORK</td>
<td>4,221</td>
</tr>
</tbody>
</table>

For the full article visit the link below:
http://www.forbes.com/sites/davidsable/2016/04/15/the-busiest-ivf-clinics-infertility-by-the-numbers-part-1/#7f80246e188c
It's a boy! A five-month-old boy is the first baby to be born using a new technique that incorporates DNA from three people, New Scientist can reveal. "This is great news and a huge deal," says Dusko Ilic at King's College London, who wasn't involved in the work. "It's revolutionary." The controversial technique, which allows parents with rare genetic mutations to have healthy babies, has only been legally approved in the UK. But the birth of the child, whose Jordanian parents were treated by a US-based team in Mexico, should fast-forward progress around the world, say embryologists.

The boy's mother carries genes for Leigh syndrome, a fatal disorder that affects the developing nervous system. Genes for the disease reside in DNA in the mitochondria, which provide energy for our cells and carry just 37 genes that are passed down to us from our mothers. This is separate from the majority of our DNA, which is housed in each cell's nucleus.

Around a quarter of her mitochondria have the disease-causing mutation. While she is healthy, Leigh syndrome was responsible for the deaths of her first two children. The couple sought out the help of John Zhang and his team at the New Hope Fertility Center in New York City.

Zhang has been working on a way to avoid mitochondrial disease using a so-called "three-parent" technique. In theory, there are a few ways of doing this. The method approved in the UK is called pronuclear transfer and involves fertilising both the mother's egg and a donor egg with the father's sperm. Before the fertilised eggs start dividing into early-stage embryos, each nucleus is removed. The nucleus from the donor's fertilised egg is discarded and replaced by that from the mother's fertilised egg. But this technique wasn't appropriate for the couple – as Muslims, they were opposed to the destruction of two embryos. So Zhang took a different approach, called spindle nuclear transfer. He removed the nucleus from one of the mother's eggs and inserted it into a donor egg that had had its own nucleus removed. The resulting egg – with nuclear DNA from the mother and mitochondrial DNA from a donor – was then fertilised with the father's sperm. Zhang's team used this approach to create five embryos, only one of which developed normally. This embryo was implanted in the mother and the child was born nine months later. "It's exciting news," says Bert Smeets at Maastricht University in the Netherlands. The team will describe the findings at the American Society for Reproductive Medicine's Scientific Congress in Salt Lake City in October.

Neither method has been approved in the US, so Zhang went to Mexico instead, where he says "there are no rules". He is adamant that he made the right choice. "To save lives is the ethical thing to do," he says. The team seems to have taken an ethical approach with their technique, says Sian Harding, who reviewed the ethics of the UK procedure. The team avoided destroying embryos, and used a male embryo, so that the resulting child wouldn't pass on any inherited mitochondrial DNA. "It's as good as or better than what we'll do in the UK," says Harding.

A remaining concern is safety. Last time embryologists tried to create a baby using DNA from three people was in the 1990s, when they injected mitochondrial DNA from a donor into another woman's egg, along with sperm from her partner. Two of the fetuses developed genetic disorders, and the technique was halted by the US Food and Drug Administration. The problem may have arisen from the fetuses having mitochondria from two sources. When Zhang and his colleagues tested the boy's mitochondria, they found that less than 1 per cent carry the mutation. Hopefully, this is too low to cause any problems; generally it is thought to take around 18 per cent of mitochondria to be affected before problems start. "It's very good," says Ilic.

Smeets agrees, but cautions that the team should monitor the child to make sure the levels stay low. There's a chance that faulty mitochondria could be better at replicating, and gradually increase in number, he says. "We need to wait for more births, and to carefully judge them," says Smeets.

Two women, one man and a baby
A Jordanian couple has been trying to start a family for almost 20 years. Ten years after they married, she became pregnant, but it ended in the first of four miscarriages. In 2005, the couple gave birth to a baby girl. It was then that they discovered the probable cause of their fertility problems: a genetic mutation in the mother's mitochondria. Their daughter was born with Leigh syndrome, which affects the brain, muscles and nerves of developing infants. Sadly, she died aged six. The couple's second child had the same disorder, and lived for 8 months.

Using a controversial "three-parent baby" technique (see main story), the boy was born on 6 April 2016. He is showing no signs of disease.
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My initial IVF journey started at 39. I had multiple IVF failures (5) at three different fertility clinics in NYC. I was given high doses of drugs during these cycles, which I responded to well, meaning I produced many follicles; however, shortly after fertilization most of the embryos would arrest and the ones transferred back in me would have a negative result. At 41, discouraged and feeling hopeless, I came across New Hope and was intrigued by their affordable Mini-IVF™ approach. After I met with my doctor, I immediately felt comfortable and hopeful again. He reviewed my medical records from my previous IVF attempts and designed a different protocol for me. Unlike other clinics, New Hope has a customized regimen for each patient, not a cookie-cutter approach. After a couple of cycles, New Hope found what regimen worked best for me. I was given less drugs, my embryos were frozen and then transferred back during my natural cycle (at 42). My husband and I now have a beautiful baby boy.

My husband and I were trying to get pregnant for about 2 years and were not successful. I consulted my gynecologist about it. After some basic screenings, my doctor did not find anything out of the ordinary and suggested that I see a specialist. During my annual visit, my gynecologist suggested that I research New Hope Fertility Center. We looked at the clinic and decided to schedule our first visit.

My treatment was Mini-IVF™. Though it was time-consuming with many clinic visits and blood tests, the treatment went very smoothly. The doctors and medical staff at New Hope were all very friendly, helpful, and willing to answer any questions we had. I felt relaxed throughout the whole process. My husband and I were lucky that I could get pregnant after our first try. Our healthy baby girl was born in February, and we couldn’t be happier with our decision.
Directions

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