I/We_____, hereby acknowledge that I/we have requested psychotherapy services from Nanci Brown, LCSW-C. Such services may include: (Please initial all appropriate choices):

___ Counseling regarding infertility and/or psychological implications of fertility treatments.

____Psychological evaluation regarding suitability to participate in one or all of the following:

____IVF or other assisted reproductive treatment using my own gametes and not involving a third-party collaborator

___Egg donation

___Recipient ___Donor

___Sperm donation

___Recipient ___Donor

___Gestational Surrogacy/Carrier

___Intended Parent ___Surrogate/Carrier

___Traditional Surrogacy (surrogate's own egg used in conception)

___Intended Parent ___Surrogate/Carrier

___PGD

___Other _____

I/we understand that not every potential participant for third-party procedures will be accepted for treatment. As necessary, I/we hereby authorize Nanci Brown, LCSW-C to discuss the results of testing and clinical interview with members of the fertility treatment team, and understand that the results of said tests will be used to assess my ability to participate. I/we hereby release Nanci Brown, LCSW-C from any liability in the event that I am not accepted for treatment.

I/we understand that there are potential psychological risks posed by counseling and evaluation. These may include risks that are presently unknown or unidentified. I/we also understand that any psychological and emotional risks may vary widely among

individuals, so it is impossible to accurately state the likelihood of my/our personal risk and I/we cannot expect any mental health professional (MHP) to state with certainty whether or not I/we may suffer any psychological consequences of counseling and evaluation. Further, should I/we accept treatment, I/we understand that there are psychological risks associated with fertility treatments, and these may include risks that are presently unknown or unidentified. Fully understanding the above, I/we voluntarily agree to proceed with counseling and/or evaluation.

I/we, as a participant(s), specifically waive the right to claim any conflict of interest on the part of the MHP, which may arise since Intended Parents may pay the third-party participant's fees. Further, I/we understand that the MHP may counsel or evaluate other proposed participants involved in my/our treatment. I/we understand that the MHP has a professional responsibility to each client, individually and regardless of the interests of other participants who might be involved. I/we acknowledge and agree that the MHP may give certain advice to one client, or make certain recommendations about a client, which may negatively impact the ultimate success of any proposed treatment for me/us or other participants. I/we specifically release the MHP (and her employees, agents, and assignees) from liability, and release and hold harmless said MHP to the extent that her actions are reasonably within standards of processional practice. None of the above may be construed, however, as a waiver or my right to pursue a negligence or malpractice claim.

_____ _____

Signature of Participant Signature of MHP

_____

Signature of Participant

_____

Date