



ART PSYCHOLOGICAL SERVICES CONSENT

I/we, _____, hereby acknowledge that I/we have requested psychological services from Betty-Shannon Prevatt, MA, LPA. Such services may include (please include all appropriate choices):

- Counseling regarding infertility and/or psychological implication 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
 - 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 Betty-Shannon Prevatt, MA, LPA to discuss the results of testing and clinical interviews with members of the fertility treatment team at _____ (medical facility), and understand that the results of said tests will be used to assess my ability to participate. I/we hereby release Betty-Shannon Prevatt, MA, LPA 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. I/we understand that psychological evaluation may involve psychological testing and will include discussions of my/our psychosocial history, current mental status, current level of support from significant others, marital satisfaction, and psychological well being. I/we understand that the evaluation process and the discussion of life experiences can be emotionally distressing. Psychological responses to the evaluation process may be, but are not limited to, the following: anxiety, depression, frustration/anger, distress, or disappointment, especially if it is decided either by myself/ourselves or by the program that I/we not proceed with donation or IVF (in vitro fertilization) as planned. Psychological risks of either the psychological evaluation or donation or IVF (in vitro fertilization) include but are not limited to: stress, interpersonal difficulties, conflicts with loved ones, impairment in daily functioning, sexual dysfunction or distress, anxiety or panic, depression, alteration of emotional well-being or triggering of traumatic memories especially involving physical or sexual abuse/trauma. 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 Betty-Shannon Prevatt, MA, LPA to state with certainty whether or not I/we may suffer any psychological consequences of counseling and evaluation. 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 Betty-Shannon Prevatt, MA, LPA, which may arise since Intended Parents may pay the third party participant's fees. Further, I/we understand that Betty-Shannon Prevatt, MA, LPA may counsel or evaluate other proposed participants involved in my/our treatment. I/we understand that Betty-Shannon Prevatt, MA, LPA has a responsibility to each client, individually and regardless of the interests of other participants who may be involved. I/we acknowledge and agree that Betty-Shannon Prevatt, MA, LPA 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 Betty-Shannon Prevatt, MA, LPA from liability, and release and hold harmless Betty-Shannon Prevatt, MA, LPA to the extent that her actions are reasonably within standards of professional practice. None of the above may be construed, however, as a waiver of my right to pursue a negligence or malpractice claim.

Signature of Participant

Signature of Participant

Betty-Shannon Prevatt, MA, LPA

Date