LANE
COUNSELING & INFERTILITY

Stephanie Lane, M.A., LPC, ATR-BC, MHP

Client Information:

Name(s):_____**Age(s):**_____

Date of Birth(s):_____

Sex: M____F____ Marital Status:_____

Address:_____

City_____**State**_____**Zip:**_____

Home Telephone:_____**Work:**_____ **Cell:**_____

Your Occupation:_____

Who Referred You? _____

May I contact the person who referred you to say "thank you"? If so, please sign giving your permission:_____

Emergency contact: (This person will only be contacted in the event of medical emergency): _____ **Telephone:**_____

Name of Fertility Clinic treating you medically and/or monitoring your cycle:

_____

Address:_____
Street Suite City State Zip

IVF Coordinator/Main contact person at agency_____

Phone:_____**Fax:**_____**Email:**_____

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Stephanie Lane, M.A., LPC, ATR-BC,
2000 E. 15th St. 450c Edmond, OK 73013

Consent to Release information for Infertility, Psychological Consultation, Assessment and Evaluation

I/We_____hereby acknowledge that I/We have requested psychological services from Stephanie Lane, LPC, ATR-BC, MHP and authorize her to provide necessary information regarding consultation to the appropriate treatment team and attorney/attorneys involved in the medical treatment and legal documentation necessary.

_____Counseling regarding infertility and/or psychological implications of fertility treatment.

_____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
☐Anonymous ☐Known

_____Sperm Donor _____Recipient _____Donor
☐Anonymous ☐Known

_____Embryo Donor _____Recipient _____Donor
☐Anonymous ☐Known

_____Gestational Carrier/surrogacy
_____Intended Parent _____Carrier/Surrogate

_____Traditional surrogacy (surrogate's own egg used in conception)
_____Intended Parent _____Surrogate

_____PGD _____Other_____

I/we understand that not every potential participant for third-party reproductive procedures will be accepted for treatment. As necessary, I/we hereby authorize Stephanie Lane to discuss the results of testing and clinical interviews with the fertility treatment team and/or attorneys involved. I/we understand that the results of said tests and evaluations will be used to assess my ability to participate as a third party donor or recipient of donated gametes or as a participant as a gestational carrier. I/we hereby release Stephanie Lane from any liability in the event that I am not accepted for treatment.

_____ _____

Signature of Participant Date

_____ _____

Signature of Participant Date

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, and 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 MHP, which may arise since intended parents may pay the third -party participant's fees. Further, I/we understand that the MHP may counsel and/or evaluate other proposed participants involved in my/our treatment. I/we understand that Stephanie Lane, MHP has a responsibility to each client, individually regardless of the interests of other participants who might be involved. I/we acknowledge and agree that

Stephanie Lane, 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 Stephanie Lane, MHP from liability and release and hold harmless Stephanie Lane 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 Date

_____ _____
Signature Date

_____ _____
Signature of MHP Date