Family Building Connections

Practice of Britta Dinsmore, Ph.D.
808 SW 15th Avenue, Portland, OR 97205
(503) 274-4994; Option 1 then Option 2 (ORM Patient Services)

CONSENT TO CONSULTATION FOR EMBRYO DONORS

Therapists Providing Psychological Services for Family Building Connections:

Britta Dinsmore, Ph.D.	Licensed Psychologist	Director
Susannah Castle, Psy.D.	Licensed Psychologist	Independent Contractor
Kate Henson, Ph.D.	Licensed Psychologist	Independent Contractor
Paula Wagenbach, Psy.D.	Licensed Psychologist	Independent Contractor

Name(s):________________________________ D.O.B.______________________
________________________________ D.O.B.______________________
Address:____
Phone Number(s):____
Email Address(s):____

Name of referring agency, fertility clinic, or attorney:______________________________
If agency or clinic is not ORM or NWSC, provide contact name, phone number, and email address:
____

NO-SHOW/LATE CANCELLATION POLICY:
Please be advised that 36 hours' notice is required for cancellations or scheduling changes or a "No-Show/Late Cancellation Fee" equivalent to 20% of the fee for the scheduled session will be charged to your referring agency or clinic.

Purpose of the Consultation: As a potential embryo donor, you are being asked to participate in a psychological consultation which is meant to help you explore and assess some of the psychological implications, risks, and benefits of donating embryos for you, your own child(ren), the recipient(s) of your donation, and the potential offspring resulting from your donation. One aim of the session is to help you evaluate whether or not donating your embryos to other recipients is the right option for you. Another goal is to help you explore some of the different decisions involved in the process of donating embryos. In addition, a thorough mental health history will be obtained, with the primary intent being to provide the recipients with as accurate of information as possible regarding the genetic background of the embryos they are receiving.

Potential Risks of the Consultation: There are potential psychological risks involved in participating in this consultation. Though this is not the intent, it is possible that such a discussion may prompt difficult feelings to surface related to donating your embryos. The consultation may also illuminate differences between you and your partner (if applicable) in terms of some of the decisions involved. It is even possible that the consultation may result in ambivalence in you or your partner about donating embryos at all.

At the conclusion of the psychological consultation, a summary report will be written that, with your signed consent, will be released to the referring agency and/or to the fertility clinic coordinating treatment. The psychological consultation is NOT meant to be a screening or evaluation. However, it is possible (though not likely) that, based on the information provided by you and summarized in the written report, your embryos may not be accepted into your referring agency or clinic's embryo donation program. If this happens, you have the right to ask for alternative options for donating your embryos.

Confidentiality: Information shared by you is confidential and will not be disclosed to anyone without your written consent. Exceptions include:
1) If services provided by another psychologist, information to Britta Dinsmore, Ph.D.,
2) Information to MindEase Billing necessary for setting up your account and billing purposes,

3) Cases of suspected abuse or neglect of a child, elder, or cognitively impaired person,
4) Cases of suspected clear and imminent danger to yourself or by you toward another person,
5) Cases where a court subpoenas your therapist to testify or subpoenas your records.

HIPAA: Federal law (HIPAA) requires us to protect the privacy of your personal information and inform you in writing of how your information may be used or disclosed and how you may access this information. If you would like a copy of our HIPAA polices, please request one.

Client Rights: You have the right to ask any questions you have about the consultation. You also have the right not to participate or to discontinue participation at any time.

Fees/Payment: When donating embryos to the ORM Embryo Donation Program, the fee for the psychological consultation will be paid for by ORM. When embryos are being donated through a directed/known arrangement and the donor(s) either have a pre-existing personal relationship with the recipients or have matched with the recipients independently of an agency (for example, through a website dedicated to matching embryo donors with potential recipients), then typically the recipients are the ones financially responsible for the embryo donor(s)' psych consultation fee. In this case, the financially responsible party must submit a signed fee agreement as well as pre-pay for the embryo donor(s)' psych consult prior to the embryo donor(s) scheduling the psych consult. In the absence of this, the embryo donor psych consult appointment may be cancelled. Under no circumstances will psychological clearance be issued without full payment for the embryo donor(s)' psych consult.

Your signature below indicates that you have read this agreement and agree to all its terms and verifies that you will not hold the psychologist who meets with you or Britta Dinsmore, Ph.D. liable for any decisions or outcomes resulting from the release of such information. It also serves as an acknowledgement that, if you requested it, you have received the HIPAA Notice of Policies and Procedures for this practice. Finally, it gives your permission for otherwise confidential information to be released to the referring clinic or agency indicated on the line below.

Referring Agency or Clinic:____

______________________________________ ______________________
Signature of Client #1 Date

______________________________________ ______________________
Printed Name of Client #1 Date of Birth

______________________________________ ______________________
Signature of Client #2 Date

______________________________________ ______________________
Printed Name of Client #2 Date of Birth

If you are a couple, please make an additional copy of the next two pages and have both partners complete one.

CLINICAL INFORMATION

I. CONTACT INFORMATION

Client #1 Name:____Date of Birth:________________Age:_____
Client #2/Partner (If Applicable) Name:______________________________Date of Birth:________________Age:_____
Address:____
Phone Number(s):____
Email Address(es):____

II. DEMOGRAPHICS:

Age:_____Ethnicity:______________________________Occupation:_____________________________________
Highest Grade or Degrees/Certifications Earned and Date Completed:___________________________________
If applicable, field of study:____

III. CURRENT RELATIONSHIPS/FAMILY INFORMATION

Marital Status (Circle all that apply):
Married Committed Relationship Single Divorced Widowed
If married or domestic partner status, how long?____
If you have been married previously, note date(s) below:

Who currently lives in your household with you?

IV. REPRODUCTIVE HISTORY

If you have children together with your current partner, list ages and gender below:

For each child indicate whether fertility treatment was utilized and, if so, whether third party assistance was involved (i.e. egg donor, sperm donor, gestational carrier). If third party assistance utilized, indicate what type:

If you have children from a prior relationship, list ages and gender below:

For each child indicate whether fertility treatment was utilized and, if so, whether third party assistance was involved (i.e. egg donor, sperm donor, gestational carrier). If third party assistance utilized, indicate what type:

Please indicate any pregnancy for you, your partner, or carried by a GC for you that did not result in a live birth:

V. FAMILY MENTAL HEALTH HISTORY (If you are genetically linked to the embryos)-

Does anyone in your family (including extended family) have a history of mental or emotional difficulties, substance abuse or dependency, eating disorders, ADHD, or learning disability? If yes, please list below:

VII. PERSONAL MENTAL HEALTH HISTORY (Both partners regardless of genetic link):

Indicate below any current or historical mental or emotional difficulties, including but not limited to depression, anxiety, substance abuse, eating disorder, ADHD, or learning disability:

If treated with psychotropic medication of any of the above issues, please indicate specifics below:

Name of Medication	**Dose**	**Frequency**	**Approximate Dates**

If counseling utilized to address any of the above issues, please indicate specifics below:

Type of Counseling (i.e. Individual, couples, group)	**Duration**	**Frequency**	**Approximate Dates**

If you did not choose to seek medication or counseling for the issue(s) identified above, what kinds of things did you do on your own to help you manage the issue(s):

Describe the current status of any mental health concerns identified above:

VI. SIGNIFICANT STRESSORS, LOSS, OR TRAUMA

Please indicate below any significant stressors, loss, or trauma, experienced in the past year:

VIII SUSBSTANCE USE PROBLEMS (Both partners regardless of genetic link):

Indicate below any current or historical problems with your use of alcohol, recreational drugs, or prescription drugs:

*Felt you were drinking/using too much?
*Had problems stopping or controlling your use?
*Had others express concern about your use?
*Participated in treatment or classes related to substance use?
*Continued to use despite significant negative consequences related to use?

If "yes," please explain below: