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INFORMED CONSENT FOR PSYCHOLOGICAL CONSULTATION RECIPIENTS AND/OR INTENDED PARENTS

Appointments: The length of the pre-cycle psychological consultation is approximately 50minutes long. Your appointment time is held exclusively for you. To avoid a late cancellation fee, please give at least hours' notice to change or cancel an appointment.

Fees:

- **Pre-Cycle Psychological Consultation for Recipients and/or Intended Parents Using Third Party Assistance: $325**
- **Subsequent Additional Routine Counseling Sessions: $165**

Payment and Insurance: Payment in full is due at the time of service. Unfortunately, the Pre-cycle Psychological Consultation for Recipients and/or Intended Parents is not eligible for insurance billing due to the fact that it is not for the purpose of diagnosing or treating a mental health disorder, which is what is required by insurance companies to reimburse for mental health services. Subsequent additional Routine Counseling Sessions *may* be reimbursed by your insurance company if you have out-of-network benefits. I do not bill insurance companies on clients' behalf but can provide paperwork for you to submit to your insurance company for potential reimbursement sent directly to you. I am not in-network with any insurance companies at this time. In order for an insurance company to reimburse for mental health services, a valid mental health diagnosis must be given.

Confidentiality: Your information is confidential and will not be disclosed without your written consent with the following exceptions:
1)If I reasonably believe you are a clear and imminent danger to yourself
2)In cases of suspected abuse or neglect of a child, elder, or cognitively impaired person
3)If a court subpoenas your records or I am court ordered to provide court testimony about you or services provided to you
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 policies, please ask for one.

Potential Benefits and Risks: The Pre-cycle Psychological Consultation for Recipients and/or Intended Parents is meant to be supportive and educational rather than evaluative. Potential benefits include gaining information, coping tools, support, and informational resources related to psychological aspects of your family building plan. Possible risks include the potential for difficult emotions to arise or for you and your partner (if applicable) to become aware of differences in perspective, goals, or priorities in relation to your fertility treatment. If you share information about an active addiction or substance abuse problem, active and severe psychiatric issue, or about current domestic violence that raises concern about you or your partner's physical or psychological health and well-being during treatment, it is possible that this could lead to a recommendation that your treatment be delayed until this issue can be addressed and better managed. Please keep in mind that a recommendation to delay fertility treatment for reasons such as these is rare---it is understood that fertility challenges and fertility treatment can be extraordinarily stressful and that many fertility patients experience depression, anxiety, and high levels of overall emotional distress. It is not uncommon for patients undergoing fertility treatment to already be in regular ongoing therapy or taking medication for a mental health concern---we don't consider this at all out of the ordinary. One of the goals of the Pre-cycle Psychological Consultation is to explore with you your stress and coping to date, to offer support, and to provide assistance with additional coping tools and resources if needed.

Client Rights: You have the right to ask any questions you have about the consultation or my education, training, or experience. You also have the right to decline to participate in the consultation, though your clinic or agency may require it as a condition of moving forward with your family building plan (per ASRM guidelines regarding standard of care).

Your signature below indicates that you have read this agreement agree to its terms, have received a copy of HIPAA policies if you requested one, and that you will not hold Britta Dinsmore, Ph.D. liable for any decisions or outcomes resulting from the consult or from the records pertaining to consult. It also gives me authorization to release a report summarizing the consultation to the following agency/clinic on your behalf:

Name of Referring Agency/Clinic Requiring Psychological Consultation:______________________________
Contact Name:________________ **Email Address:**________________ **Phone #:**__________

Signature Patient #1:______________________________ **Date:**____________________
Printed Name Patient #1:______________________________ **DOB:**____________________
Signature Patient #1:______________________________ **Date:**____________________
Printed Name Patient #1:______________________________ **DOB:**____________________

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. FAMILY/HOUSEHOLD INFORMATION

__ Married __ Committed Relationship How long have you been in this relationship?

For couples, list any children you have together and the age of each child:

List any children either of you have from a prior relationship and the age of each child:

Client #1:

Client #2:

III. HISTORY OF EFFORTS TO CONCEIVE AND FERTILITY TREATMENT TO DATE

For heterosexual couples, how long did you attempt to conceive on your own before seeking reproductive assistance?__________

For all patients/couples,

How long have you been working with reproductive specialists?____

Please any note prior fertility treatments including approximate dates and outcomes:

Please note any prior pregnancies, including those carried by a GC on your behalf; list approximate dates and outcomes:

Name of your current fertility clinic?_____________________________________ Physician:__________________________

Specify your current fertility treatment plan; indicate any type of third party assistance to be used (check all that apply):

__ IUI __ IVF __ Donor Egg __ Donor Sperm __ Donor Embryo __ Gestational Carrier

IV. MEDICAL AND MENTAL HEALTH INFORMATION

List any complementary treatments either partner has used or are using to support your care (i.e. acupuncture, yoga, meditation):

Client #1:

Client #2:

Note any history of depression, anxiety, eating disorder, substance abuse or mental health issues so that coping strategies and relapse prevention (if applicable) can be discussed:

NATURE OF CONCERN	THERAPY __ __ Past or __ Current	MEDICATION __ __ Past or __ Current	OTHER TOOLS/COPING
Client #1:			
Client #2:			

V. CONSULTATION NEEDS

What, if any, specific concerns do you have about your current family building plan? Are there any topics that you have particular questions about or would like to be sure to discuss?