Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

Gestational Surrogacy Commissioning Couple-Intended Parent Packet Review Consent Form

I have read the provided information on the following treatment(s)/procedure(s):

- ❒ **Dream Discount Plus Program Flyer**
- ❒ **Southwest Florida Surrogacy Program General Patient Information**
- ❒ **Gestational Surrogacy Price List**
- ❒ **Dream Discount Plus Program Consent**
- ❒ **Patient Information Summary Assisted Reproductive Technologies**
- ❒ **Gestational Surrogacy Commissioning Couple-Intended Parent Consent For Therapy**
- ❒ **Consent For Criminal History Check**
- ❒ **Consent For Cryopreservation of Embryos**
- ❒ **FET Agreement In Gestational Surrogacy Procedures General and Monthly Consent Form**
- ❒ **ART Glossary of Terms**
- ❒ **Gestational Surrogacy Commissioning Couple-Intended Parent Packet Review Consent Form (this form)**
- ❒ **Testing For Sexually Transmitted Diseases**
- ❒ **Semen Analysis & Anti-Sperm Antibody Screening Patient Information**
- ❒ **Ovarian Superovulation Injectable Medications General Information**
- ❒ **ASRM Fact Sheet: Side Effects of Gonadotropins**
- ❒ **Antibiotic Therapy During ART General Information**
- ❒ **Human Chorionic Gonadotropin (HCG) Patient Information**
- ❒ **Ovarian Hyperstimulation Precautions**
- ❒ **Early Pregnancy Patient Instructions**

I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have read and understand the above patient information packet(s), and I have had an opportunity to ask questions regarding the above topic(s) and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medication(s) and/or the performance of particular procedure(s) and wish to proceed with the above treatment(s) and procedure(s).

_____	___/___/___	_____	___/___/___
Patient Name (print)	Date	Patient Name (signature)	Date
_____	___/___/___	_____	___/___/___
Guardian (if necessary)	Date	Witness	Date
_____	___/___/___		
Practitioner	Date		

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