This form to be used by "Genetic – Intended Parents" and a "Gestational Carrier" in Gestational Surrogacy
An Agreement to Cryopreserve Embryos must also be executed if embryo cryopreservation is to be done
Each party must also have legal representation and have executed Parenting Agreements in addition to this consent.

Karande & Associates, S.C. doing business as

INVIA FERTILITY SPECIALISTS

Consent for Couple and Gestational Carrier Participating in Gestational Surrogacy

Genetic Mother – Intended Parent: _____ Date of Birth: _____

Genetic Father – Intended Parent: _____ Date of Birth: _____

Gestational Carrier: _____ Date of Birth: _____

Husband of Gestational Carrier: _____ Date of Birth: _____

Physician: _____

Program: _____

Introduction

In vitro fertilization (IVF) and embryo transfer (ET) are treatments that help infertile couples achieve pregnancy. The technique involves four main steps: 1.) stimulating egg production in the woman's ovaries (ovulation induction with the use of fertility hormones; 2.) removing the eggs from her ovaries (egg retrieval by ultrasound guided needle aspiration of ovarian follicles; 3.) fertilization of the eggs with sperm in the laboratory (insemination) and 4.) transferring fertilized eggs (embryo(s) transfer) into the uterus to establish a pregnancy.

The existence of the embryos outside of a woman's body creates the possibility of placing these embryos into a second woman (gestational carrier) who then carries the pregnancy. The intention following the delivery is to unite the baby or babies with the genetic donors; the couple who will be the rearing parents.

Gestational Surrogacy treatment is considered medically appropriate when a woman (the intended parent) has:

- No uterus, a congenitally deformed uterus, or a uterus that is unable to support a pregnancy,
- Another medical condition that precludes her from successfully carrying a pregnancy.

- (Repeated) failed in vitro fertilization

In such situations the Intended Parent is still capable of becoming a "genetic mother". This document explains the treatment and describes the major risks. In addition, the responsibilities of the gestational carrier are discussed.

Pre-treatment Recommendations:

The gestational carrier should avoid any activity, behavior, or medication during treatment that would reduce the chances of conceiving or increase the risk to an unborn child. Below are recommendations for the gestational carrier:

1. Take prenatal vitamins on a daily basis. This vitamin should contain folic acid, which reduces the chance of giving birth to a child with a neural tube defect (e.g. spina bifida).
2. Smoking must be avoided before and during treatment. It is also contraindicated during pregnancy.
3. Recreational drugs are absolutely contraindicated, including but not limited to: cocaine, marijuana, heroin, LSD, PCP, ecstasy.
4. Ingestion of aspirin or aspirin-like products (e.g. Motrin®, Advil®, Anaprox®, Ibuprofen, Naprosyn, Aleve®, etc. should be avoided during treatment. You MAY take Tylenol.
5. The use of alcohol should be eliminated
6. The use of all prescription and over-the-counter medications should be discussed with a physician before starting a treatment cycle.

Description of the Treatment

Gestational Surrogacy treatment is done in conjunction with IVF and involves several steps. Success cannot be guaranteed at any and all of these steps. If optimal results are not appreciated at any point in the process, it may be recommended that treatment be stopped and the cycle cancelled. The steps of the treatment are discussed below.

1. Ovulation Induction: In most cases the Genetic Mother – Intended Parent will take medications to stimulate the development of multiple ovarian follicles (the fluid-filled cysts in the ovary that contain the eggs). In the non-medicated approach, no medications are administered to stimulate the ovaries.
2. Egg Retrieval: The Genetic Mother – Intended Parent has the eggs removed from her ovaries.
3. Insemination of the Eggs: The eggs and sperm will be placed together in the laboratory and incubated in an effort to achieve possible fertilization and growth of the embryos. Attempts to fertilize the eggs may occur by conventional laboratory methods, or intracytoplasmic sperm injection (ICSI) may be done.
4. Preparation of the Endometrium: The uterine cavity of the Gestational Carrier will be hormonally prepared prior to the embryo transfer to allow implantation to occur. The Gestational Carrier will be administered hormones, including estrogen and progesterone, to prepare the endometrium for implantation. If a "fresh" embryo

transfer is to be performed, the cycles of the Gestational Carrier and Genetic Mother – Intended Parent will be synchronized.

5. Embryo Transfer: One or more embryos will be transferred into the uterus of the gestational carrier.
6. Embryo Cryopreservation (Freezing): Following the embryo transfer, any remaining embryos of suitable quality may be cryopreserved and stored for future embryo transfer. Refer to "***Embryo Cryopreservation Agreement***".

The Gestational Carrier participates in steps 4 and 5. The Genetic Mother – Intended Parent participates in steps 1, 2, 3, and 6.

Definition of Terms

We understand some or all of the following surgical, medical, and/or diagnostic procedures may be performed as part of our participation in Gestational Surrogacy, subject to our Physician's medical judgment. We will execute specific consents for the procedures deemed necessary by our physicians as part of our treatment.

(a.) Pre-IVF Screening: Determination by medical history, physical examination, and standard infertility tests that we are candidates for this procedure.

(b.) Ovulation Induction: The use of fertility drugs (such as Lupron, hMG, FSH and human chorionic gonadotropin (hCG)) to stimulate the growth and maturation of ova (eggs) in the ovary.

(c.) Laboratory Tests: Serial blood samples may be taken from the genetic mother - intended parent and/or gestational carrier to monitor hormone secretions from the ovary and pituitary gland.

(d.) Ultrasound: Transvaginal and abdominal ultrasonography is a diagnostic procedure using sound waves to provide a picture of the ovarian follicles in order to monitor the response to the ovulation induction medications. Ultrasound examinations are also used to evaluate the endometrium of the Gestational Carrier.

(e.) Egg Retrieval: Vaginal introduction of a needle into the ovary, guided by real time ultrasound, to obtain one or more eggs. Monitored anesthesia care (MAC), conscious sedation and/or a local anesthetic is used to minimize discomfort.

(f.) Semen Specimen: Collection of a semen specimen (typically by masturbation) or thawing of previously cryopreserved sperm, and laboratory treatment of the specimen to prepare it for fertilization of the oocyte(s).

(g.) Fertilization: Placing the egg(s) and the sperm together in a suitable medium to allow fertilization to occur. If there is no evidence of fertilization after 48 hours of incubation, the oocyte(s) and sperm will be disposed of in a medically acceptable manner.

(h.) Intracytoplasmic Sperm Injection (Micromanipulation): Intracytoplasmic sperm injection (ICSI) is a procedure in which a sperm is injected directly into the oocyte (egg) to increase the possibility of fertilization.

(i.) Embryo Culture: Provision of a suitable microenvironment that allows continued development of the fertilized ova (egg(s)) and embryo(s).

(j.) Embryo Transfer: Placement of the embryo(s) into the uterus by means of a small tube inserted through the cervix into the uterus.

(k.) Assisted Hatching (Micromanipulation): An opening is made in the zona pellucida (the outer protective layer of an embryo) in an effort to increase the possibility of embryonic implantation.

(l.) Cryopreservation of Embryo(s): If there are more embryos than can be safely transferred in a single embryo transfer event, extra embryos can be cryopreserved (frozen) for use at a later time.

(m.) Luteal Phase Support: During the first two weeks following the egg retrieval procedure, additional hormonal support such as progesterone and/or hCG may be provided.

(n.) Pregnancy Testing: Following embryo transfer, blood tests may be obtained to assess hormone levels and to detect pregnancy. If pregnancy is confirmed, the gestational carrier will continue luteal phase support (estrogen and progesterone), and proceed with obstetrical care through a physician acceptable to all involved parties.

Selection of the Gestational Carrier

The Intended Parents acknowledge that they have selected the Gestational Carrier. The Intended Parents understand that the Program will require an appropriate medical evaluation of the Gestational Carrier. If in the reasonable professional judgment of the Physician and/or the Program, this evaluation indicates that it is not appropriate to proceed with the gestational surrogacy arrangement, the Intended Parents will be so notified.

The Intended Parents understand that even if the evaluations of the Gestational Carrier and her spouse disclose no reason not to proceed, there is still no guarantee of the suitability of the Gestational Carrier, and Intended Parents bear full responsibility for their selection of the Gestational Carrier.

The Physician will collect a medical history from the Gestational Carrier. The accuracy or completeness of this information is outside of the control of the Program. In this connection, the Intended Parents acknowledge that the Program will rely on the information presented by the Gestational Carrier. Except as indicated below, with regard to the stated diagnostic testing, neither Program nor Physician make an independent verification of any information provided by the Gestational Carrier or by the Husband of the Gestational Carrier. Neither Physician nor Program shall be liable to any party by reason of the inaccuracy of any representation made to them by the Gestational Carrier or her husband. Neither Physician nor Program shall be liable to any other party for any claim based in whole or in part on information which Physician or the Program could have learned had they made any independent investigation of any information provided by the Gestational Carrier or her Husband.

Medical Testing

The Intended Parents acknowledge that the following diagnostic tests will be performed on the Gestational Carrier. Tests are performed on blood, urine or cervical samples and cultures only. These tests will be conducted in accordance with parameters recommended by The American Society of Reproductive Medicine and the Centers for Disease control and Prevention, where appropriate:

Gestational Carrier

- Cervical cultures for Gonorrhea and Chlamydia
- Blood type and Rh
- Syphilis testing
- Rubella
- Cytomegalovirus (CMV)-IgG and IgM:
- HTLV-1 & 2:
- Hepatitis B and Hepatitis C
- HIV 1 & 2

If the Gestational Carrier is 40 years old or older the following tests will have been performed:

- EKG
- Chest x-ray
- Metabolic Panel
- Serum cholesterol and/or lipid panel
- Mammogram
- Serum fasting blood sugar &/or 2 hr Post prandial

Even when properly administered, these tests have their own limitations and may not produce reliable results. Consequently, even if the tests described in this paragraph show results within normal limits, the Intended Parents understand the risk that the Gestational Carrier may not be disease free. Similarly, no guarantee is given, or can be given, that any resulting child or children will be disease free.

The Gestational Carrier and the Husband of the Gestational Carrier acknowledge that the following diagnostic tests will be performed on the Intended Parents. Tests are performed on blood, urine or cervical samples and cultures only. These tests will be conducted in accordance with parameters recommended by The American Society of Reproductive Medicine and the Centers for Disease control and Prevention, where appropriate:

Medical Testing
Genetic Parents-Intended Parents

Genetic Mother – Intended Parent

- Cervical cultures for Gonorrhea and Chlamydia
- Pap Smear
- Blood type and Rh
- Prolactin and FSH
- Syphilis testing
- Rubella
- Cytomegalovirus (CMV)-IgG and IgM:
- HTLV-1 & 2:
- Hepatitis B and Hepatitis C
- HIV 1 & 2
- Cystic Fibrosis screening will be offered
- Other tests may be offered based on ethnic background

Genetic Father – Intended Parent

- Cytomegalovirus (CMV)-IgG and IgM:
- HTLV-1 & 2:
- Hepatitis B and Hepatitis C
- HIV 1 & 2
- Semen Analysis
- Blood Type and Rh

Human Immunodeficiency Virus (HIV) Testing

All of us hereby consent to the administration of any and all tests deemed necessary by the Physician or the Program and any person or corporation acting as an employee, agent or subcontractor of the Physician or the Program, to test for the existence of antibodies to the human immunodeficiency virus (HIV), or the presence of HIV itself, which is capable of causing acquired immunodeficiency syndrome, commonly known as AIDS. We understand that the test procedure involves withdrawal by needle of a small amount of blood, and that the blood sample will be subject to laboratory testing. The risks of the procedure, which include but are not limited to bruising, soreness, and a minor risk of infection, have been explained to us.

It has been explained to us that our blood may register a “false positive’ i.e. the test may indicate that we have an antibody to HIV present in our blood when the HIV virus itself is not actually present. We have been informed that if our test results are positive, all treatments may be cancelled. It has also been explained to us that a negative antibody test result does not guarantee the absence of HIV in our blood, nor does such a test result guarantee that we do not have AIDs.

We, the Intended parents and the Gestational Carrier and the Husband of the Gestational Carrier consent to other testing for infectious diseases as is deemed necessary by the Physician or the Program.

Risks. We realize and acknowledge that certain risks are associated with IVF/ET, including the following:

(a). Response to ovulation induction (under or over response): Attempts to induce ovulation with fertility medication(s) may fail due to poor follicular development, poor hormonal stimulation response, spontaneous LH surge or for other reasons. If attempts to induce ovulation fail, the physician will determine the need to change or discontinue the course of treatment.

There is a small risk that attempts to induce ovulation may cause "ovarian hyperstimulation syndrome" (OHSS) – a condition in which elevated levels of estrogen (estradiol) are present and the ovaries enlarge and can twist. OHSS can be associated with pelvic pain, nausea, vomiting, ovarian torsion and possible rupture, and, in extreme cases, can lead to organ failure, and rarely death. If it appears that wife's ovaries are becoming abnormally (over) stimulated, fertility medication(s) may be discontinued, and attempts to retrieve ova (egg(s)) may be abandoned.

(b.) Egg Retrieval Procedure and Anesthesia: The egg retrieval and/or embryo transfer procedure(s) may cause some physical discomfort. Though rare, possible difficulties of transvaginal ultrasound guided needle aspiration of oocyte(s) (egg(s)) are:

(1.) the aspiration may fail;
(2.) bladder, bowel, and/or other organs may be damaged;
(3.) bleeding and/or infection may take place and require further treatment; and
(4.) adverse effects of anesthesia or analgesic may be encountered.

(C.) Micromanipulation Techniques:

Intracytoplasmic sperm injection (ICSI): ICSI is a procedure developed to help infertile couples undergoing IVF for male factor infertility, and when there is a risk of poor fertilization. It involves the injection of a single sperm into the cytoplasm of the egg. This process increases the likelihood of fertilization where there are abnormalities in the number, quality or function of the sperm.

We understand the ICSI process may damage a small percentage of eggs. Approximately 30% of ICSI cycles performed in the US in 1998 resulted in a live birth, which is comparable to traditional IVF. Because ICSI is a relatively new technique, long term data concerning future health and fertility of children conceived through ICSI is not available. Because some causes of male infertility are genetic in origin, male offspring may have fertility problems as adults.

The importance of genetic evaluation of males with extreme oligospermia (sperm count <10 million per milliliter) or azoospermia (no sperm in the ejaculate) has recently been established. Men with extreme oligospermia may have abnormal chromosomes (karyotype) or abnormalities of the male chromosome (microdeletions of the Y-chromosome). Men with congenital absence of the vas deferens may have mutations of the cystic fibrosis gene.

Assisted Hatching: Assisted hatching is a laboratory procedure intended to improve implantation of embryos in patients undergoing IVF. In assisted hatching a small opening is made in the zona pellucida (the membrane that surrounds the embryo). It is postulated that this opening in the zona pellucida may enhance subsequent hatching and implantation of the embryo. Assisted hatching may be beneficial in selected patients. Assisted Hatching will be performed at the discretion of the medical and embryology team.

We understand that these micromanipulation procedures are relatively new and all potential complications resulting from the use of ICSI and/or Assisted Hatching may not yet be known. Additionally, the process of employing these techniques may result in damage to the sperm, ova (egg) and/or embryo(s) that may limit the ability for fertilization and/or ongoing embryo viability. We understand that InVia Fertility Specialists have not guaranteed the success of these procedures or the health of any child developing from any of the above procedures. We understand and agree that the Program physician and personnel will determine the value of, and provide these procedures during the treatment cycle.

(D.) No Guarantee of the Clinical Outcome of IVF/ET: We understand that we may not achieve a viable pregnancy (live birth) via these procedures. We have discussed our particular fertility factors and chances for success with our Program physician and personnel. We acknowledge, agree and understand that InVia Fertility Specialists. nor the Program physicians and/or personnel have made any promises or guarantees regarding the success rate or results of IVF/ET or the health and characteristics of any child or children that may be conceived by these procedures.

(E.) Legal Risks of Gestational Surrogacy Arrangement: We understand that there are also legal risks in this gestational surrogacy due to the lack of Illinois laws or judicial decisions dealing with (1.) the legal rights and responsibilities of participants in gestational surrogacy program and (2.) the legal status of frozen embryos. We realize that there is a risk that some of our understandings and intentions as set forth herein, may, at some future time, be held to have no legal effect.

We understand that some of the provisions of this Consent may, at some future time, be held unenforceable in whole or in part. It is our intention that all provisions of this consent are severable. In the event that any of them shall be held to be invalid by a court, the remaining provisions shall continue to have full force and effect. Developing laws may require changes in some of the Program's policies, procedures and requirements, and we agree to be bound by any such changes. We understand that the legal uncertainties include, but are not limited to, the following:

1. Legality of gestational surrogacy and applicability of laws governing termination of parental rights and adoption to a GS arrangement.
2. Extent to which the Intended Parents may exercise dominion and control over embryos.
3. Extent to which the Intended Parents may direct activities of the Gestational Carrier.
4. Inheritance rights of children born as a result of a gestational surrogacy arrangement
5. Inheritance rights of embryos.
6. Possible refusal of the legal system in our state to enforce the gestational surrogacy arrangement as all of us intend at this time for it to be enforced.
7. Possible illegality or unenforceability of the ***Parenting Agreement*** among the Intended Parents and the Gestational Carrier and her husband, particularly

with regard to the extent to which a Gestational Carrier may be permitted to avoid her agreement and seek custody of a child born as a result of the gestational surrogacy arrangement.

Benefits of IVF/ET

While no guarantees have been made to us concerning the results and outcomes of IVF/ET, we wish to undergo IVF and embryo transfer to the gestational carrier to improve the chance of having a successful pregnancy. Program physician and/or personnel have discussed with us the likelihood of wife and/or Gestational Carrier becoming pregnant in any one cycle.

Alternate Procedures

We acknowledge that Physician has explained to us the medical and surgical alternatives to IVF/ET, use of Gestational Carrier, and the benefits and risks associated with each one.

Embryo Transfer

Generally, the embryo transfer into the Gestational Carrier is performed 3 to 5 days after the egg retrieval. At the time of the embryo transfer, fertilization results and the development of the embryos will be reviewed, allowing for decision-making regarding the number of embryos that will be transferred. Increasing the number of embryos transferred will increase the chances of pregnancy, but will also increase the risk of a multiple pregnancy (e.g., twins, triplets, etc.). Embryos that are not transferred ("extra" embryos) are examined and, if they are of suitable quality, can be cryopreserved (frozen) for transfer at a later date.

Embryos that result from abnormal fertilization (i.e. polyspermy – when more than one sperm fertilizes an egg) will be discarded, as they have no chance of developing normally. In addition, embryos which fail to develop properly (e.g. fail to divide, demonstrate other significant abnormalities of development) will also be discarded. If in the physician'' best judgement, eggs or embryos have failed to develop and are therefore not viable, they will not be transferred and will be discarded.

Intended parents hereby agree and acknowledge that any of our sperm, ova, or embryo(s) that Physician concludes, in the exercise of his/her professional judgment, are non-viable or otherwise not medically suitable for continued use in IVF, will be disposed of.

To perform the embryo transfer, the gestational carrier is placed in the same position as if she were having a pelvic exam. A speculum is placed in the vagina and the cervix is visualized. Then the embryologist loads the embryo(s) into a catheter, which the physician inserts through the cervical canal and into the uterine cavity. The catheter is examined by the embyologist to confirm that the embryos have been released from the catheter into the uterine cavity. Activity should be limited the day of the embryo transfer. Thereafter, normal activity can be resumed.

Following the embryo transfer the gestational carrier will continue taking estrogen and progesterone as advised by the physician.

Generally, 11 to 14 days after embryo transfer, a blood pregnancy test will be done. If this test is found to be positive, a repeat pregnancy test will be done as ordered

by the physician. If the blood pregnancy tests remain positive, a vaginal ultrasound will be done to determine the status of the pregnancy.

We have had the opportunity to discuss ET with our physician and all our questions have been answered to our satisfaction.

Cryopreservation of Embryos (Freezing)

Extra embryos that remain after the embryo transfer procedure will be examined to assess their quality, in order to determine their suitability for freezing. Embryos that are not of sufficient quality will not be frozen and will be discarded. Frozen embryos may be thawed at a later date for embryo transfer without the need for ovulation induction medications or the egg retrieval procedure. We have been informed and understand that if we wish to cryopreserve (freeze) any embryos not transferred to the uterus, Genetic Mother and Father – Intended Parents must sign a separate consent document. The storage and disposition of such embryos shall be controlled by the terms of the ***Embryo Cryopreservation Agreement*** that we have executed concurrently with this consent**.**

We hereby knowingly and voluntarily release InVia Fertility Specialists. physicians and personnel, and all of their respective employees and agents, from any and all actions, claims, costs, expenses, and liabilities, including, but not limited to attorneys' fees, court costs, damages, settlements, compromises, judgments, and any other losses or expenses they incur or for which they may be responsible with respect to such discarding of fertilized or unfertilized egg(s), sperm and/or embryo(s).

Ownership of Embryos

The Intended Parents understand and agree that unless we release or transfer to Physician, each embryo resulting from the fertilization of the Genetic Mother – Intended Parent's ovum by the Genetic Father – Intended Parent's sperm is the joint property of the Intended Parents. Both of us must join in a request for additional transfers

No Sale of Embryos or Babies.

We understand and agree that buying and selling of embryos or babies shall not occur. The Intended Parents agree to pay all actual medical and related expenses incurred in connection with the necessary medical work-up and diagnostic procedures, the oocyte retrieval, the embryo transfer procedure, the pregnancy and the delivery of the Gestational Carrier, and to reasonably compensate Gestational Carrier for her services, but neither the Intended Parents nor anyone else on their behalf may transfer anything of value to the Gestational Carrier, the Program or the Physician in consideration for release of the resulting child or children to the Intended Parents.

Agreement by Intended Parents to Accept Parental Responsibility.

We, the Intended Parents, hereby affirm our intention and agreement that if a live birth results from this gestational surrogacy agreement, we will be the mother and father of the resulting child or children, through Genetic Mother – Intended Parent's adoption of the child or children and/or appropriate legal proceedings, and we will thereafter have the same legal rights and responsibilities as if the child or children had been carried and delivered by Genetic Mother – Intended Parent. Intended Parents hereby forever waive

any right we might otherwise have to disclaim responsibility for the child or children, even if it/they is/are born with serious developmental disabilities. We, Intended Parents, are willing to accept a child with medical problems in any degree, realizing that this is one of the risks of having children by any means.

It is our intention and understanding that neither the Gestational Carrier nor the Husband of the Gestational Carrier will have parental rights to the child.
Further, under Illinois law, a man is presumed to be the natural father of a child if he and child's natural mother are or have been married to each other when the child was conceived or born after the marriage. Thus, under Illinois law, in the gestational surrogacy arrangement, there will exist a presumption that the Gestational Carrier is the natural mother of the child or children born and that her husband is the father of such child or children.

Agreement to Undergo Maternity/Paternity Testing.

The Intended Parents and Gestational Carrier agree to submit to DNA fingerprinting in order to establish the paternity and maternity of the child or children resulting from this gestational surrogacy arrangement.

Inheritance Rights of Children Resulting from Gestational Surrogacy Arrangements; Inheritance Rights of Embryos.

It is the intention and understanding of all of us that any child/children born of this arrangement will have inheritance rights from the Intended Parents and no such rights from the Gestational Carrier or the Husband of the Gestational Carrier. The Intended Parents also understand that there are legal uncertainties concerning the inheritance rights of cryopreserved (frozen) embryos. If we have other children and have wills that make provision for our "children," it is possible that the term could be interpreted to include our embryos. If we die intestate (without wills), it is possible that our embryos could be held to be our "children" under the intestate succession laws and could therefore be entitled to share our property with our other children or to receive all of our property if we have no other children. We recognize that if we wish to avoid these uncertainties or to insure the inheritance rights of our children or other heirs, the safest course of action is for us to execute wills that expressly disinherit our embryos.

The Gestational Carrier and the Husband of the Gestational Carrier understand that given the small risk that legally they may be regarded as the "natural" parents of the child or children born as a result of this arrangement, they may need to take action to expressly disinherit such child or children. The Gestational Carrier and the Husband of the Gestational Carrier agree to proceed accordingly.

Agreement by Gestational Carrier and the Husband of the Gestational Carrier to Terminate Parental Rights.

The Gestational Carrier and the Husband of the Gestational Carrier agree to take whatever steps and undergo whatever legal proceedings are necessary to terminate any legally recognized parental rights which they may have

Effect of Death or Divorce of the Intended Parents.

Both Genetic Father and Genetic Mother intend and agree to form a parent-child relationship with the child resulting from this gestational surrogacy arrangement, even in the event that we should divorce, including a divorce prior to the birth of the child. In such event, our rights and responsibilities will be the same as those of any other divorced parents. Custody could be awarded to either or both of us, and the non-custodial parent would have a child support obligation. We also intend and agree that the death of one of us shall have no effect on the parent-child relationship between the other of us and the child.

Treatment Outcomes

The development of a pregnancy following IVF treatment is dependent on many factors, some of which include: the age of the woman, the diagnosis, the number of previous cycles of treatment, the number and quality of the eggs, the quality of the semen sample and the number and quality of the embryos that are transferred. Despite repeated attempts of this treatment, there is the possibility that a pregnancy will not occur. An overview of some of the more common risks of pregnancy is discussed below:

Miscarriage: The risk of miscarriage in the general population is 15-20%. The risk of miscarriage increases with the age of the women that produces the eggs. Many miscarriages are associated with lower abdominal cramping and bleeding, but do not necessarily require treatment. In some cases, however, complete removal of the pregnancy tissue must be accomplished by a surgical procedure call a dilatation and curettage (D&C). The procedure is usually performed under anesthesia in the operating room and involves placing a suction tube into the uterine cavity to remove the pregnancy tissue.

Multiple and/or Tubal (Ectopic) Pregnancy: IVF/ET may result in multiple pregnancy and/or ectopic (pregnancy outside the uterus) pregnancy. Risks related to multiple gestation include premature birth and risks to the resulting children associated with prematurity, fetal death, lifestyle restrictions for the pregnant women; and increased risk of complications of pregnancy, such as toxemia and gestational diabetes.

Congenital Anomalies: Most infants who have been born following IVF are normal. The rate of congenital abnormalities (birth defects) in the general population is 2-3% and is not different in babies conceived with IVF. It is important to be aware that genetic abnormalities, structural abnormalities, mental retardation and other abnormalities may occur following IVF or pregnancies that are conceived naturally.

Chromosomal Abnormalities: The risk of chromosomal abnormalities increases with the age of the woman who provides the eggs. A chorionic villus biopsy or a genetic amniocentesis can assess the chromosomal status of the fetus(es) If a chromosomal abnormality is identified, termination of the pregnancy may be considered

Psychological Risks: Undergoing infertility treatment is psychologically stressful. Anxiety and disappointment may occur at any of the phases described above.

There are many complex and sometimes unknown factors, which may prevent the establishment of pregnancy. Known factors which may prevent the establishment of pregnancy include, but are not limited to, the following:

1. The ovaries may not respond adequately to the medications.
2. Technical problems including inadequate visualization or the position of the ovaries may prevent retrieval of the eggs.
3. There may be failure to recover an egg because ovulation has occurred prior to the time of the egg retrieval. The egg(s) may not be recovered.
4. The eggs may not be normal.
5. The male partner may be unable to produce a semen sample or the semen sample may be of insufficient quantity or quality.
6. Fertilization of the eggs and sperm to form embryos may not occur.
7. Cell division of the embryos may not occur.
8. The embryos may not develop normally.
9. Embryo transfer into the uterus of the gestational carrier may be technically difficult or impossible.
10. If the transfer is performed, implantation(s) may not result.
11. If implantation occurs, the embryo(s) may not grow or develop normally.
12. Equipment failure, infection, technical problems, human error and/or other unforeseen factors may result in loss or damage to the eggs, semen sample and or embryo(s).

There are many risks that may be associated with pregnancy including, but not limited to, the following:

Bleeding: Vaginal bleeding may occur at any time during pregnancy. Bleeding may be a sign of miscarriage. Bleeding may occur later in the pregnancy and may be a sign of placenta previa, which is a low-lying placenta that covers the cervix or placental abruption, which is detachment of the placenta from the wall of the uterus. Both of these conditions may result in premature labor and delivery. Uterine bleeding can also occur following a delivery. Management of the bleeding during pregnancy could include bed rest, dilation and curettage, transfusion, emergency cesarean section and/or a possible hysterectomy depending on the circumstances.

Infection: Infections may occur in the bladder, kidneys, and the uterine cavity or at other sites during a pregnancy. Infections could necessitate the use of oral antibiotics. In some cases, a hospitalization may be necessary with the administration of intravenous antibiotics. In rare cases, an infection in the uterine cavity following a delivery could result in clot formation in the pelvic vessels that may require anticoagulant therapy.

Diabetes: The hormones during pregnancy put a woman at risk for developing diabetes. It is estimated that between 1-12% of women develop diabetes during pregnancy. The risk increases with a multiple pregnancy. Initial management may include an adjustment of the diet and possible insulin injections. Diabetes can have a detrimental affect on the fetus. Testing of the fetal well being may be indicated and may include ultrasound examinations and recordings of the fetal heart rate.

Toxemia: Toxemia (pre-eclampsia) is a condition that develops during pregnancy and results in high blood pressure, fluid retention and loss of protein in the urine. It complicates up to 10% of pregnancies. It occurs more frequently in women during their first pregnancy. Other factors that put a woman at risk for the

development of toxemia include a history of high blood pressure, kidney problems, diabetes or multiple pregnancy. Initial treatment includes bed rest. In some cases hospitalization and early delivery may be indicated. In rare cases seizures may occur.

Premature Labor: The initiation of labor with uterine contractions generally occurs between weeks 37-42 of the pregnancy. The onset of the labor may be considered premature if it occurs before the 37th week of pregnancy. Premature labor complicates approximately 10-12% of pregnancies. Its incidence is increased in multiple pregnancies. Premature labor can result in premature delivery of an infant unable to survive without some assistance. Premature birth is the single greatest cause of death or disability of newborns. Treatment of premature labor could include a hospitalization with extended best rest and medical therapy.

Route of Delivery: Most deliveries can be accomplished via the vaginal route. However, in approximately 25% of cases there will be the need to perform a cesarean section. In cases of multiple pregnancy there is an increased chance of a cesarean section. A cesarean section is performed by delivering the baby through an incision made in the lower abdomen and the uterus. It can be performed under genera, epidural or spinal anesthesia. Following a cesarean section a 2-5 days hospitalization will be necessary. After discharge, recovery may take up to 4-6 weeks. Complications from delivery could include infections, hemorrhage, blood clots in the legs (deep vein thrombosis) or lungs (pulmonary embolism) and other complications that may necessitate additional surgery (i.e. dilation and curettage, hysterectomy) or medical treatment.

Postpartum: It may take up to 1-2 months following a delivery before a woman is able to return to her normal activities. The average weight gain during pregnancy is 25 pounds. Some women do not return to their pre-pregnancy weight. Some of the other physical changes of pregnancy that may not reverse themselves include the development of stretch marks in the abdomen, change in the shape and texture of the breasts and vaginal relaxation which can cause protrusion of the colon, bladder or intestines into the vagina that could produce symptoms and require surgery. Following the delivery of the infant you may also experience feelings of depression or anxiety.

General Well-Being: Pregnancy affects women in different ways. While some women feel fine during the pregnancy, others have complaints of nausea, vomiting, fatigue, loss of energy and may develop various discomforts (i.e. lower abdominal aching, back pain). These symptoms and others may affect a woman's sense of well being and ability to function at home or at work. Depending on the nature and degree of the symptoms a woman may not be able to function at the work place and therefore experience lost income. Following a delivery, between 50-70% of women experience the "postpartum blues" characterized by mood swings, depression, fatigue, anxiety, confusion and difficulty with concentration. Less than 10% of women experience the more severe symptoms of postpartum depression that may necessitate medical intervention.

Time Commitment: Pregnancy lasts an average of 280 days, but may be shorter or last longer depending on the circumstances. During the pregnancy the women

will make frequent visits to her obstetrician to monitor the pregnancy. It may be necessary to remain in the vicinity all or part of the pregnancy.

Mortality Rate: The overall mortality rate associated with pregnancy is 0.01% (1 in 10,000). Some of the reasons for death include the following: embolism, hypertensive disease, bleeding, ectopic pregnancy, infection, stroke and complications from anesthesia.

We understand that all decisions regarding each step of the IVF/ET procedure, including insemination, fertilization and embryo transfer, will be made by our IVF/ET physician and/or personnel based on his or her independent judgement. We understand that our IVF Program physician and/or personnel may decide not to proceed with procedures because of complications or possible risks, either to the husband, wife, or the potential child, or because of other reasons, and we agree to rely on his or her decisions in this regard. Further, we understand that if we do not agree with our Program physician and/or personnel as to the IVF/ET procedures, we may be referred to other Program physician(s) and/or personnel or transfer to another fertility program of our choosing.

Release of Medical Information: Gestational Carrier and Husband of the Gestational Carrier understand and agree that confidential medical information pertaining to diagnostic testing, and treatment information regarding the gestational surrogacy treatment cycle and any information regarding a possible pregnancy, maternity care and pregnancy outcome may be disclosed to the Intended Parents. Likewise confidential medical information regarding the Intended Parents (including, but not limited to diagnostic testing, ovulation induction cycle information, embryo quality, etc., may be disclosed to the Gestational Carrier and the Husband of the Gestational Carrier.

Records: We understand that the Program will prepare and maintain written records regarding our participation in the IVF/ET Program. The Program will maintain the confidentiality of this information, and will disclose such information only as authorized by the one of us to whom the information applies or as required by applicable law. We understand that we have the right to inspect these records during regular business hours, upon at least 48 hours notice to the Program, and to receive copies of these records upon payment of reasonable costs.

(a.) Filming, Videotaping and/or Photography: We authorize the filming, videotaping, and/or photographing of the female reproductive organs, ova (egg(s)), sperm and/or embryos during the course of these procedures, and the use of these images in medical publications and/or presentations, provided that any identity is not revealed by the images or the presenter.

(b.) Society for Assisted Reproductive Technology (SART) and Centers for Disease Control (CDC): We understand that information about our assisted reproductive technology procedures are reported by the Program to the Society for Assisted Reproductive Technology ("SART"), which maintains a national database of cycle specific data. We also understand that Data from your ART procedure will also be provided to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility clinic Success Rate and Certification Act requires that CDC collect data on all assisted reproductive technology cycles performed in the

United States annually and report success rates using these data. Because sensitive information will be collected on you, CDC applied for and received an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that CDC has that identifies you will not be disclosed to anyone else without your consent. We also understand that pursuant to federal law, as part of SART's routine data validation procedures, we may be contacted by professional reviewers and asked to confirm information included in SART's database. We agree to participate in this data validation process, unless we have indicated to the Program our refusal to do so.

(c) Third-Party Payers: In addition, we understand that we may be required to authorize disclosure of medical information to third-party payers (for example, health insurance providers) in order to obtain payment for services.

Financial Commitment:

We understand that insurance coverage for any or all of the above procedures may not be available. We acknowledge that we have been made aware of our financial obligations and we have made appropriate financial arrangements and understand we are responsible for payments on services performed regardless of whether a pregnancy is achieved. We have been informed that if we should suffer any physical injury as a result of participation in this activity, all of the necessary medical facilities are available for treatment. We understand, however that we cannot expect to receive any payment for hospital expenses or any financial compensation for such an injury. We also understand that we are financially responsible for any other medical costs incurred.

Acknowledgement of Informed Consent and Authorization

I acknowledge that I, the undersigned, am voluntarily participating in the InVia Fertility Specialists. in vitro fertilization and gestational carrier services.

I believe that I am a low-risk candidate for sexually transmitted diseases (STDs) such as hepatitis, genital herpes and/or HIV virus (AIDs). I agree to be screened for STDs including HIV antibodies and I understand that I will be informed if the results are positive. I agree to inform InVia Fertility Specialists. if I engage or have engaged in any activities that put me at risk for STDs (including but not limited to: new or multiple partners, needle sharing, tattooing, body piercing).

As the gestational carrier, I understand I must abstain from sexual intercourse and/or use contraception during my treatment cycle in order to avoid becoming pregnancy with my own egg(s).

As the genetic mother/father - intended parent(s), I realize that I have other alternatives including adoption or continuing our relationship without children.

I acknowledge that I have read and fully understand this written material and that all of my questions concerning the treatment have been fully answered to my satisfaction.

I am aware that there are other advanced reproductive therapy centers in this area that offer this treatment and I have agreed to have the treatment at InVia Fertility Specialists.

By participating, I accept the responsibilities, conditions and risks involved as set out in this document and as explained to me by my physician and/or staff at InVia

Fertility Specialists. In addition, I consent to the techniques and procedures required to participate in gestational carrier in vitro fertilization as described in this document and as they have been explained to me.

I acknowledge and agree that my acceptance into treatment and my continued participation is within the sole discretion of InVia Fertility Specialists.

I understand that the ability to participate in another cycle of treatment will be determined by my physician and the InVia Fertility Specialists. I understand that I can withdraw from treatment at any time. I also understand that I am financially responsible for any other medical costs incurred by me.

Release of Liability: We hereby agree to release InVia Fertility Specialists., physicians and personnel, and all of their respective employees and agents, and hold harmless from any and all actions, claims, costs, expenses and liabilities, including but not limited to attorneys' fees, court costs, damages, settlements, compromises, judgments, and any other losses or expenses, other than medical negligence, that we incur or for which they may be responsible with respect to any claim or legal action arising out of our participation in the Program and authorized by signing this document.

We acknowledge by our signatures below that we have read the foregoing and that all questions we have asked have been answered to our satisfaction, and that we understand the answers. We acknowledge receipt of a copy of this informed consent document.

Signature of Gestational Carrier	Date	Signature of the Husband of the Gestational Carrier	Date
Printed Name	Date of Birth	Printed Name	Date of Birth
Signature of Genetic Mother-Intended Parent	Date	Signature of Genetic Father-Intended Parent	Date
Printed Name	Date of Birth	Printed Name	Date of Birth
Signature of Physician	Date	Printed Name of Physician	Date
Signature of Witness	Date	Printed Name of Witness	Date

Attachment 1 Addendum to Gestational Carrier Consent – Transfer of Embryo(s) to Gestational Carrier for implantation **(Signatures of Intended Parents required)**
Attachments 2 and 3 Notary Forms

Attachment (1)

ADDENDUM TO GESTATIONAL CARRIER CONSENT

We, the intended parent(s)(name) _____and (name)_____ are contracting with a Gestational Carrier (name and Social Security#) _____ _____to have transferred into her uterus our embryo(s). These embryo(s) have been generated from the sperm of _____ (genetic father, known sperm donor or anonymous donor) and egg(s) from _____ (genetic mother, known donor or anonymous donor.) We hereby grant the release of these embryo(s) to INVIA FERTILITY SPECIALISTS, for the express purpose of being transferred into the uterus of (name) _____ our Gestational carrier. We, _____and _____ are the intended parent(s) and understand that our Gestational Carrier will relinquish any and all rights to any/all children created from the transfer of the aforementioned embryos into her uterus.

_____ _____

Female Partner's Signature Date Printed Name

_____ _____

Male Partner's Signature Date Printed Name

_____ _____

Witness to Signature Date Printed Name

Notary Attachment (2)

_____	_____
Signature of Genetic Mother-Intended Parent Date	Signature of Genetic Father-Intended Parent Date
_____	_____
Printed Name Date of Birth	Printed Name Date of Birth

STATE OF ILLINOIS

_____ County

Personally came before me this _____ day of _____, 200__, the persons who executed the foregoing instrument and acknowledged the same.

_____
Notary Public, State of Illinois

My Commission: _____

Notary Attachment (3)

_____	_____
Signature of Gestational Carrier Date	Signature of Husband of Gestational Carrier Date
_____	_____
Printed Name Date of Birth	Printed Name Date of Birth

STATE OF ILLINOIS

_____ County

Personally came before me this _____ day of _____, 200__, the persons who executed the foregoing instrument and acknowledged the same.

_____
Notary Public, State of Illinois

My Commission: _____