Female Patient Name: _____ Social Security #: _____

Partner's Name: _____ Social Security #: _____

Karande & Associates, S.C. doing business as

InVia Fertility Specialists

INFORMED CONSENT – THERAPEUTIC DONOR INSEMINATION PROGRAM (If patient is married, partner must sign)

Description, Explanation and Informed Consent

I/we, _____, being of legal age, hereby consent to my/our artificial insemination with semen of a donor or donors. I/we hereby authorize my physicians and/or employees of INVIA FERTILITY SPECIALISTS to perform such procedures.

I/we understand that even though the insemination may be repeated as often as recommended by my/our physician at INVIA FERTILITY SPECIALISTS there is no guarantee on their part, or assurance that pregnancy or full-term pregnancy will result.

I/we agree to rely upon the discretion of the physicians at INVIA FERTILITY SPECIALISTS in selection of sources for donor semen. I/we acknowledge and agree that the identity of the donor will not be revealed to me unless I make use of designated donor as listed here: _____.

I/we understand that the semen used for insemination will be frozen. I/we understand that there is a remote possibility of transmission of infectious disease via artificial insemination.

I/we understand that if pregnancy does result, there is the possibility of complications of childbirth or delivery, the birth of an abnormal infant or infants, undesirable hereditary tendencies of such infant or infants, or other adverse consequences. I/we also understand that other risks, complications, or side effects may result from the use of artificial insemination by donor procedures. I have been given the opportunity to ask questions about the procedure, the methods being used and the risks and hazards involved and I/we believe that I/we have sufficient information to give this informed consent. I/we have discussed alternative treatments with my/our physician at INVIA FERTILITY SPECIALISTS and it is my/our decision to accept the risks and hazards referred to above.

I/we agree to notify INVIA FERTILITY SPECIALISTS of any infant or infants born as a result of Therapeutic Donor Insemination.

From the moment of conception I/we accept the act of conception as my own act and acknowledge the child or children produced as my/our legitimate child or children and the heir of my/our body with all the rights and privileges accompanying such status.

All of my/our questions regarding INVIA FERTILITY SPECIALISTS – Therapeutic Donor Insemination Program's Informed Consent have been

answered. I have read the consent and acknowledge receipt of a copy of this consent.

_____	_____	_____
Date	Signature of Female Patient	Female Name - Print
_____	_____	_____
Date	Signature of Partner	Partner's Name

As one of the members of INVIA FERTILITY SPECIALISTS, by my signature indicate that the foregoing consent was read, discussed, and signed in my presence.

_____	_____	_____
Date	Signature of Witness (Female Patient)	Witness Name – Print
_____	_____	_____
Date	Signature of Witness (Partner)	Witness Name – Print

NOTE: If you are unable to have this consent witnessed by a staff member at INVIA FERTILITY SPECIALISTS or FULLY UNDERSTAND THE CONSENT, please notify the INVIA FERTILITY SPECIALISTS medical staff. We will provide you with further information and a witness. If you wish to sign the consent outside of INVIA FERTILITY SPECIALISTS, please have the consent notarized.

State of _____, County of _____ s.s., I, the undersigned, a Notary Public in and for the said County in the State aforesaid; DO HEREBY CERTIFY that

_____ personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this _____ day of _____, 20___.

Commission expires on: _____, 20_____.

_____
(Notary Public)

(Notary Seal)