

# TRACY E. CRAIN, M.S., LPC-S, LCDC

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## CONTRACT FOR PSYCHOLOGICAL EVALUATION

This is a consent for psychological evaluation, which is being conducted at the request of a physician as part of the process required for your participation as a (an) egg donor/gestational surrogate/intended parent) in an Assisted Reproductive Technologies (ART) procedure. It is therefore somewhat different than other psychological services. It is important for you to understand how a psychological evaluation for ART differs from more traditional psychological evaluations. While the results of this evaluation may or may not be helpful to you personally, the goal of this evaluation is to provide information to the physician requesting the evaluation about how you are functioning psychologically. In agreeing to this evaluation, you agree to hold me harmless should your application for ART services be denied based on the findings documented in my report.

The psychological evaluation could include the administration of standardized, empirically validated psychological tests and a structured interview. I will ask questions about your psychosocial history and will assess your psychological functioning and your ability to provide informed consent about medical procedures in which you are seeking to participate. I will then submit a report to the egg donor/surrogacy agency, egg bank, reproductive attorney and/or fertility practice, any of which are working in accordance with your participation role.

Your participation in this evaluation is entirely voluntary. I will not conduct the evaluation without assurance that you are acting of your own free will and as evidenced by your signature on this document. You have the right to stop the evaluation at any time. If, at any time, you have a question, please feel free to ask me. In addition, if at any time you need a break from the evaluation, please let me know and we can stop. Once the evaluation is completed, the evaluation will be sent to the physician/clinic and will become a part of the intended parents permanent medical record.

I have read and agreed to the above information.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

