THE COOLEY LAW FIRM

SHELLY BOOTH COOLEY,
Attorney at Law
10161 Park Run Drive, Suite 150
Las Vegas, Nevada 89145

NEW CLIENT INTAKE SHEET - ASSISTED REPRODUCTIVE TECHNOLOGY (ART)

DATE: ___________ REFERRED BY____

MATTER TYPE (Check all that apply):

☐ Gestational Carrier Agreement (Carrier NOT genetically related to child)
☐ Traditional Surrogacy Agreement (Surrogate genetically related to child)
☐ Egg Donor Agreement
    ☐ Known ☐ Anonymous
☐ Sperm Donor Agreement
    ☐ Known ☐ Anonymous
☐ Adjudication of Parentage/Birth Order
    ☐ Before birth of the resulting child   ☐ After birth of the resulting child

INTENDED PARENT 1:

FULL LEGAL NAME (as appears on passport):____

SSN.:______________ SEX:______ GENDER: ______ PREFERRED PRONOUNS: ________________

DATE OF BIRTH:_____________PLACE OF BIRTH (STATE AND COUNTRY):_____________________

HOME PHONE: ___________________________ CELL PHONE: ________________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: ____________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS?_________________________________

IS INTENDED PARENT KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? ☐YES/☐NO

Marital Status: ☐ NO SPOUSE/PARTNER

☐ Married ☐ Registered Domestic Partner ☐ Unmarried, Committed Relationship ☐ Unmarried/Single

NAME OF SPOUSE/PARTNER:____

DATE OF MARRIAGE/REGISTRATION:__________________________________

INTENDED PARENT 2:

FULL LEGAL NAME (as appears on passport):____

SSN.:______________ SEX:______ GENDER: ______ PREFERRED PRONOUNS: ________________

DATE OF BIRTH:____________PLACE OF BIRTH (STATE AND COUNTRY):____________________

HOME PHONE: __________________________ CELL PHONE: _______________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: __________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS?_______________________________

IS INTENDED PARENT KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? ☐YES/☐NO

Marital Status:

☐ Married ☐ Registered Domestic Partner ☐ Unmarried, Committed Relationship ☐ Unmarried/Single

NAME OF SPOUSE/PARTNER:____

DATE OF MARRIAGE/REGISTRATION:________________________________

**** PLEASE PROVIDE A COPY OF LEGAL IDENTIFICATION FOR EACH INTENDED PARENT****

– If U.S. Citizen and Resident: Driver's License and Passport.

– If Non-U.S. Citizen or Resident: Passport

ATTORNEY FOR INTENDED PARENT(S):____

DONOR

☐ Egg/Ovum

☐ Sperm

Has Donor Contract already been prepared and executed? ☐Yes/☐No (If yes, provide copy.)

FULL LEGAL NAME (as appears on passport):____

SEX: M/F SOCIAL SECURITY NO.:________________________DATE OF BIRTH:________________

HOME PHONE: __________________________ CELL PHONE: _______________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: __________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS:_________________________

IS DONOR KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? ☐YES/☐NO

Marital Status: ☐ NO SPOUSE/PARTNER

☐ Married ☐ Registered Domestic Partner ☐ Unmarried, Committed Relationship ☐ Unmarried/Single

NAME OF SPOUSE/PARTNER:____

DATE OF MARRIAGE/REGISTRATION:__________________________________

ATTORNEY FOR DONOR:____

SPOUSE/PARTNER OF DONOR: (If applicable)

FULL LEGAL NAME (as appears on passport):____

SEX: M/F SOCIAL SECURITY NO.:_________________________DATE OF BIRTH:_________________

HOME PHONE: ___________________________ CELL PHONE: ________________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: ____________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS:__________________________

IS SPOUSE/PARTNER KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? YES/ NO

**** PLEASE PROVIDE A COPY OF LEGAL IDENTIFICATION FOR DONOR AND PARTNER****

– If U.S. Citizen and Resident: Driver's License and Passport.

– If Non-U.S. Citizen or Resident: Passport

GESTATIONAL CARRIER:

FULL LEGAL NAME (as appears on passport):____

SEX: M/F SOCIAL SECURITY NO.:_________________________DATE OF BIRTH:_________________

HOME PHONE: ___________________________ CELL PHONE: ________________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: ____________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS:__________________________

IS GESTATIONAL CARRIER KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? ☐YES/☐NO

Marital Status: ☐ NO SPOUSE/PARTNER

☐ Married ☐ Registered Domestic Partner ☐ Unmarried, Committed Relationship ☐ Unmarried/Single

NAME OF SPOUSE/PARTNER:____

DATE OF MARRIAGE/REGISTRATION:__________________________________

ATTORNEY FOR GESTATIONAL CARRIER:____

SPOUSE/PARTNER OF GESTATIONAL CARRIER: (IF APPLICABLE)

FULL LEGAL NAME (as appears on passport):____

SEX: M/F SOCIAL SECURITY NO.:________________________DATE OF BIRTH:________________

HOME PHONE: __________________________ CELL PHONE: _______________________________

E-MAIL ADDRESS:____

COUNTY, STATE & COUNTRY OF CURRENT ADDRESS: ___________________________________

HOME ADDRESS: ____

____

HOW LONG AT THIS ADDRESS:_________________________

IS SPOUSE/PARTNER KNOWN TO BE NATIVE AMERICAN OR ALASKA NATIVE? ☐YES/☐NO

**** PLEASE PROVIDE A COPY OF LEGAL IDENTIFICATION FOR**

GESTATIONAL CARRIER AND PARTNER**

– If U.S. Citizen and Resident: Driver’s License and Passport.

– If Non-U.S. Citizen or Resident: Passport

MEDICAL CLINIC:

MEDICAL CLINIC NAME:____

MEDICAL CLINIC ADDRESS:____

MEDICAL CLINIC TELEPHONE:____

MEDICAL CLINIC CONTACT NAME:____

AGENCY: (☐ NOT APPLICABLE - INDEPENDENT JOURNEY)

AGENCY NAME:____

AGENCY ADDRESS:____

AGENCY TELEPHONE:____

AGENCY CONTACT NAME AND EMAIL:____

PROCEDURAL INFORMATION:

1. OVUM SOURCE: Will the oocytes (eggs) be provided by Intended Parent(s) or Egg Donor?

   ☐ Intended Parent(s) ☐ Donor:☐ Anonymous/☐ Known_________________________________

Is the Donor a Relative or Personal Friend? ☐ N/a ☐ Yes ☐ No

Does the Egg Donor have an infectious disease?

☐ Yes* ☐ No ☐ N/a

* If YES, please specify:

____ ____________________________

Base Compensation: $______________________ OR ☐ Altruistic/Non-Compensated

Anticipated start date of Donor's medication:_________________

Anticipated Retrieval Date:______________________

2. SPERM SOURCE: Will the oocytes (eggs) be fertilized by Intended Parent(s) or Sperm Donor?

☐ Intended Parent(s) ☐ Donor:☐ Anonymous/☐ Known________________________________

3. EMBRYO SOURCE: Will the embryos be provided by Intended Parent(s) or Donor?

☐ Intended Parent(s) ☐ Donor:☐ Anonymous/☐ Known________________________________

EMBRYO(S) TRANSFER DATE:____________________ ☐Singleton ☐ Twin ☐_______________

4. CARRIER: Will the resulting embryo(s) be transferred to Intended Mother or a Gestational Carrier?

☐ Intended Mother ☐ Gestational Carrier ☐ N/a

Is the Gestational Carrier a relative or personal friend? ☐ N/A ☐ Yes ☐ No

Base Compensation: $______________________ OR ☐ Altruistic/Non-Compensated

Anticipated start date of Gestational Carrier's medication?__________________

DATE OF CONFIRMATION OF PREGNANCY:____

GESTATIONAL CARRIER'S WEEK OF GESTATION:_________________________________

EXPECTED DUE DATE:____

EXPECTED HOSPITAL NAME:____

HOSPITAL ADDRESS:____

EXPECTED CITY, COUNTY AND STATE OF BIRTH:_________________________________

MEDICAL SCREENING:

Has Prospective Gestational Carrier completed a medical evaluation relating to the anticipated pregnancy? _

☐ N/A ☐ Yes ☐ No (If yes, please complete)

PHYSICIAN'S FULL NAME:____

PHYSICIAN'S ADDRESS:____

PHYSICIAN'S TELEPHONE NUMBER:_____________________________________

DATE OF REPORT & MEDICAL EVALUATION CLEARANCE:____________________

PSYCHOLOGICAL CLEARANCE:

Has Prospective Gestational Carrier completed a psychological evaluation relating to the anticipated pregnancy? ☐ N/A ☐ Yes ☐ No (If yes, please complete)

PHYSICIAN'S FULL NAME:____

PHYSICIAN'S ADDRESS:____

PHYSICIAN'S TELEPHONE NUMBER:_____________________________________

DATE OF REPORT &PSYCHOLOGICAL EVALUATION CLEARANCE:_______________

LEGAL LAST NAME OF CHILD(REN):____________________________________

Will the Gestational Carrier be provided with Health Insurance?

☐ Yes ☐ No ☐ Using Gestational Carrier's health insurance

If using Gestational Carrier's health insurance, has Gestational Carrier's policy been reviewed to ensure that it does **NOT** exclude maternity medical coverage for surrogates? ☐ N/A ☐ Yes ☐ No

(If Home Address outside U.S.A.) HAVE YOU CONSULTED WITH A LOCAL ATTORNEY IN YOUR HOME COUNTRY (If you have not yet done so, please do so before completing this form.)____

(If applicable) ARE THERE ANY SPECIAL REQUIREMENTS UNIQUE TO YOUR COUNTRY WITH REGARD TO HOW THE BIRTH CERTIFICATE SHOULD BE PREPARED? (I.e., Same sex parents cannot be listed on birth certificate)________________________________

____

EMERGENCY CONTACT:

____

Name (First, Last) Relationship Address Telephone

GESTATIONAL CARRIER/DONOR AGREEMENT TERMS:

Have Contract Terms Been Discussed? ☐ Yes ☐ No

If YES, please specify terms that you believe are agreed upon:

Selection of Physician?____

Maximum number of embryos to transfer per cycle?_______________________________

Termination and Selective Reduction of Pregnancy?_______________________________

Maximum number of fetuses Carrier agrees to carry?_______________________________

Base Compensation: $_____________________ OR ◻ Altruistic/Non-Compensated

Additional Compensation for Twins?________________________Triplets?__________________________

Pump breast milk?____

Non-Accountable monthly Allowance?____

Life Insurance?____

Counseling?____

Escrow Account?____

Escrow Deposits required?____

Health Insurance?____

Maternity Clothing Allowance?____

Carrier's Lost Wages?____

Partner's Lost Wages?____

Housekeeping expenses?____

Child Care expenses?____

Travel Expenses?____

Guardian(s) for child(ren)?____

____

____