BETTE GALEN, MSW, LCSW______________________________________

975 Arther Godfrey Road, #305 Miami Beach, Fl 33140

General Consent for Psychological Counseling

and/or Psychoeducational Counseling

Third Party Reproduction and Related Issues

I, _________________ (hereinafter referred to as Client) hereby acknowledge that I am receiving psychological and/or psychoeducational counseling for persons experiencing infertility or infertility related issues ('Counseling Sessions'). Patient understands that the scope of such Counseling Sessions is limited to issues of infertility and acknowledges that Counseling Session with Bette Galen shall not be intended as an alternative for counseling for any psychological problems beyond infertility. Those receiving counseling services generally report that the experience is helpful. However, counseling may bring up emotions that can be difficult and Bette shall not be liable for any adverse effects resulting from the sessions, including but not limited to depression, anxiety, sleep disorders and/or any other mental problem.

Client understands that the Counseling Sessions are confidential; however, Client is aware that some confidential records maintained by Bette Galen may be required to be sent to a clinic to satisfy the clinics requirement of a third party psychoeducation consult. Once a record is sent to the requested clinic, that information may be accessed and viewed by the employees of that clinic. Client further waives any expectation to confidentiality if, at any time, the mental health professional must disclose any such confidential information as required by law or a court of competent jurisdiction. In the event Bette believes, at any time, the Client is a danger to themselves and/or others, Client acknowledges that Bette reserve the right to take any and all actions available to her under the law to protect the Client and/or others from harm.

By signing below I hereby acknowledge and agree that:

I have read the information on this consent and understand the information

I have had all my questions answered.

I consent to participate in the counseling session

By signing below, I acknowledge that any scanned, faxed, or other electronic or photo static or similar copy of this document be deemed an original for all purposes including but not limited to any investigation, audit, administrative or judicial proceedings.

______________________	____________________	____________________
Client Signature	Print Name	DOB/ DATE
______________________	____________________	____________________
Client Signature	Print Name	DOB/DATE