ADOPTION & SURROGACY
BY HAUSMANN & HICKMAN, P.A.
EST. 1997

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GESTATIONAL SURROGATE PROFILE

PERSONAL

Name: _____ Maiden Name (if different)_____

Address: _____

How long have you lived at your current address? _____

Preferred contact telephone number (include area code):

Daytime: _____ Evening: _____ Cell: _____

E-mail address:_____ _____

Facebook address: _____

Birth Date: _____ Birth Place _____ Social Security Number:_____

Religion: _____ Ancestry/Nationality: _____Race:_____

Language(s)spoken: _____

Marital Status: _____ Husband's/Companion's Name:_____

Husband's employer: _____

Your Physical Description: Height: _____ Weight: _____

OCCUPATIONAL BACKGROUND

Present occupation: _____

Name/address of employer: _____

Telephone number: _____ Work hours: _____

How long have you been employed with this position? _____

Can you be called at work? Yes ( ) No ( )

Is your employer aware of your surrogacy plans? Yes ( ) No ( ) _____

Will your employer allow flex days for medical appointments? Yes ( ) No ( ) _____

Are your entitled to sick time and/or maternity leave? Yes ( ) No ( ) _____

Do you have any disability coverage through your employment? Yes ( ) No ( ) _____

GENERAL CONSIDERATIONS

Is your family aware of your surrogacy plans? Yes ( ) No ( )

Do you have a reliable support system? Yes ( ) No ( ) Please explain:_____

Who will help you during your pregnancy? _____

Have you ever applied or are you currently applying to be a gestational carrier at any other medical facility, law firm, or agency? Yes ( ) No ( ) If yes, please list:

_____

_____

Have you ever applied to be a gestational carrier at any other medical facility, law firm and/or agency and been told that you do not meet the facilitie's criteria to be a gestational carrier? Yes ( ) No ( )

If yes, please explain: _____

_____

Would you be willing to assist:

Same sex couple:	Yes ( ) No ( )
Single male:	Yes ( ) No ( )
Single female:	Yes ( ) No ( )
Couple using an egg donor:	Yes ( ) No ( )
Couple using a sperm donor:	Yes ( ) No ( )
A couple with children:	Yes ( ) No ( )
A Couple with a different ethnicity	Yes ( ) No ( )
A Couple with a different religion	Yes ( ) No ( )
An international couple	Yes ( ) No ( )
Do you have health insurance?	Yes ( ) No ( )
Have you reviewed a your current policy?	Yes ( ) No ( )
Does it have maternity coverage?	Yes ( ) No ( )
Does it have a surrogacy exclusion?	Yes ( ) No ( )

Health insurance company name _____

Address: _____

Phone: _____

Policy Number: _____

Is your health insurance provided through a state agency or program? Yes ( ) No ( )

Please confirm your insurance does not contain an exclusion for surrogate pregnancy, No ( ) _____

PREGNANCY HISTORY

How many times have you been pregnant? _____ Dates of prior pregnancies: _____

Please explain if applicable: Abortion: Yes ( ) No ( ) • Miscarriage: Yes ( ) No ( ) • Normal Delivery: Yes ( ) No ( )

C-Section: Yes ( ) No ( ) • Date of last delivery _____

Please explain any complications during any pregnancy or delivery: _____

_____

Are the children with you now? Yes ( ) No ( ) Ages of children _____ Sex of children _____

HEALTH INFORMATION

Are your menstrual periods regular? Yes ( ) No ( ) How long is your monthly cycle? _____

Do you have bleeding between periods? Yes ( ) No ( ) Anything unusual about your monthly cycle? Yes ( ) No ( )

Please explain: _____

_____

How many days does your period last?_____

Are you presently using birth control? Yes ( ) No ( ). If yes, please state current method: _____

How long have you used this method of birth control? _____

Are you willing to undergo amniocentesis or other diagnostic tests to determine the presence of birth defects? Yes ( ) No ( )

If there was a serious problem with the fetus and the intended parents wanted to abort, would you be willing to do so?
Yes ( ) No ( )

Have you ever been seen by a professional for mental health issues? Yes ( ) No ( )

If yes, please explain: _____

Do you smoke cigarettes? Yes ( ) No ( ) How often? _____ For how long? _____

Does any member in your household smoke cigarettes? Yes ( ) No ( )

Do you drink alcohol? Yes ( ) No ( ) How often? _____

Have you ever used illegal drugs? Yes ( ) No ( ) Please detail: _____

_____

Have you ever had surgery? Yes ( ) No ( ) If yes, state reasons and results. _____

_____

List all serious illnesses and hospitalizations: _____

_____

List all medications you are presently taking, dosages and the reasons for each:

Blood type: _____ RH Factor: Positive ( ) Negative ( )

Have you ever received a blood transfusion? Yes ( ) No ( )

EDUCATIONAL HISTORY

Number of years attended: Grade School _____ High School _____ College _____

Educational Achievements: _____

Educational Goals: _____

LEGAL REPRESENTATION

Does an attorney represent you currently? Yes ( ) No ( )

If so, Name: _____

Address: _____

Telephone Number: _____

GENERAL QUESTIONS

Please list any problems you or your spouse have experienced with the law including, but not limited to, any arrests, convictions and sentences:

_____

_____

Have you or your spouse ever served any time in jail? Yes ( ) No ( )

If so, how much time did you serve, where and why?

_____

Briefly explain why you wish to be a gestation carrier and your understanding of what being a gestational carrier and your understanding of what this will entail:

_____

_____

_____

Generally please describe yourself, i.e. your personality, hobbies, and interests: _____

_____

_____

What qualities would you consider most important that the intended parents have?

_____

Would you permit the intended parents in the delivery room? Yes ( ) No ( )

Would you allow the intended parents' names to be placed on the birth certificate? Yes ( ) No ( )

Would you be willing to pump, freeze and ship your breast milk if the intended parents requested it for their child? Yes ( ) No ( )

In case of a pregnancy with multiples, how do you feel about selective reduction?

_____

What kind of support and encouragement do you expect for being a gestational carrier?

_____

How does your husband/partner feel about your participation in this program?

_____

Would your husband/partner be willing to undergo medical screening and a psychological evaluation if required by the doctor or intended parents?

Yes ( ) No ( ) _____

Do you lease a car, own a car, or have access to public transportation? Yes ( ) No ( )_____

Is your vehicle insured? Yes ( ) No ( )

Do you have a valid driver`s license? Yes ( ) No ( )

What is your driver's license number?_____

Have you ever been a gestational carrier before? Yes ( ) No ( )

If yes, please give details: _____

_____

Have you ever placed a child for adoption? Yes ( ) No ( )

Are you adopted? Yes ( ) No ( )

Are any of your children adopted? Yes ( ) No ( )

Please rate how important the following factors were to you in making the decision to apply to be a gestational carrier
(1 = most important; 10 = not important)

A. I like being pregnant, but don`t want any more children of my own _____

B. I need the money _____

C. Giving an infertile couple a child would bring me happiness _____

D. Other please specify: _____

EXPENSES

In Gestational Surrogacy, Florida law allows the intended parents to pay the reasonable legal, living, psychological, medical, and psychiatric expenses that are directly related to the surrogacy. Please estimate the amount that you feel that you should be reimbursed, exclusive of actual medical expenses, for this undertaking.

$ _____

VERIFICATION AFFIDAVIT & RELEASE OF INFORMATION

I verify that the information contained on the attached Surrogate Profile is true and correct to the best of my knowledge and belief. I understand that the information I am providing will be used and relied upon by the intended parents, their physicians and attorney.

In my written and verbal communications in connection with my surrogacy plan, I have not provided any false or misleading information of any kind including information concerning my family, or myself regarding background or medical history.

I herein authorize Hausmann & Hickman, P.A. to share all information provided to them with the court and any intended parents. In the event that I have provided or provide in the future any misleading or false information or in any way violate the terms of the Agreement, I herein authorize Hausmann & Hickman, P.A. to share my information, provided by myself and my physicians with other Surrogacy Practitioners, law enforcement authorities and the prospective parents through all communication medium.

_____ _____

Surrogate Mother Date

_____ _____

Surrogate's Husband/Companion Date

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SURROGATE MEDICAL RECORDS RELEASE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Soc. Sec. Number: _____

Date of Birth: _____ Health Rec. # (if known): _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

_____

Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ problem list
☐ list of allergies
☐ medication list
☐ immunization record
☐ most recent discharge summary
☐ bills, invoices, itemized statements
☐ most recent history and physical
☐ insurance claim forms
☐ laboratory results from (date) _____ to (date) _____
☐ x-ray and imaging reports from (date) _____ to (date) _____
☐ consultation reports from (doctors' names) _____
☐ entire record from (date) _____ to (date) _____
☐ other _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

HAUSMANN & HICKMAN, P.A.
MICHELLE M. HAUSMANN, ESQ.
AMY U. HICKMAN, ESQ.
2423 Quantum Blvd.
Boynton Beach, Florida 33426

for the purpose of: a Surrogacy Matter.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to **Hausmann & Hickman, P.A.** I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hausmann & Hickman, P.A. or an independent attorney.

_____ _____
Patient Date

_____ _____
Signature of Witness Date

STATE OF _____)

COUNTY OF _____)

I HEREBY CERTIFY that on this day, before me, the undersigned Notary Public, personally appeared _____, who well known to be the person described in or who has produced _____ as valid identification and who, after first being duly sworn, deposes and states that he/she executed the foregoing authorization to disclosure health information before me and that he/she executed same freely and voluntarily for the purposes therein expressed.

SWORN TO and subscribed before me this _____day of _____, _____.

_____

Notary Public

State of