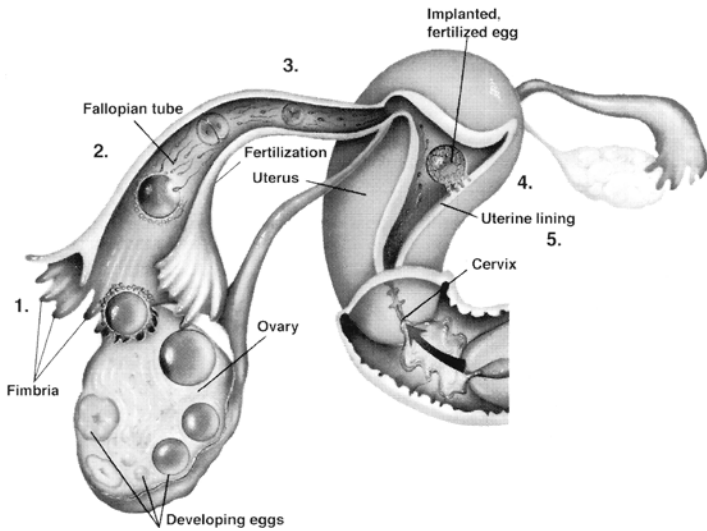


## SPONTANEOUS CONCEPTION

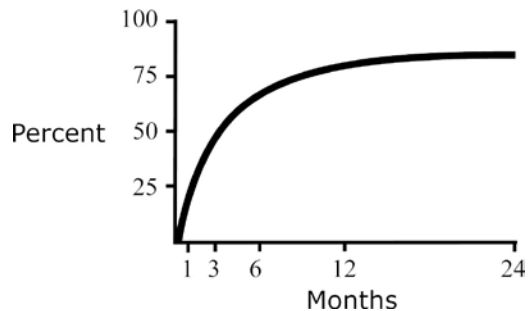


1. Fourteen days prior to the beginning of a new cycle, an ovarian follicle releases a microscopic egg.
2. Sperm, which can wait in the Fallopian tubes for several days, must fertilize the egg within 12 to 16 hours of ovulation.
3. The fertilized egg (embryo) moves through the Fallopian tube and starts to divide the day after fertilization. In two days, it has 4 cells, in three days, 8 cells and in six days it has over 100 cells.
4. Female hormones estrogen and progesterone, produced by the ovulating follicle, prepare the lining of the uterus for implantation.
5. Six to eight days after fertilization, the embryo hatches out and implants into the lining of the uterus and starts to produce the pregnancy hormone (hCG).

## INFERTILITY

Infertility is defined as no ongoing pregnancy after 6-12 months of sexual activity without contraception.

A. Speed of conception in the general population:



Monthly pregnancy probability:

- 1<sup>st</sup> month: 20-25%
- 13<sup>th</sup> month: 1.5%
- 25<sup>th</sup> month: 0.1%

B. There are three groups of causes of infertility:

1. Male Factor: Sperm production and sperm fertilizing capacity
2. Ovulation: Egg production, egg quality and preparation of uterine lining for implantation
3. Passage: The joining of sperm and egg in the Fallopian tubes and transport of the fertilized egg

C. Female age and fertility:



Loss of female fertility:

The decrease in female fertility potential is due to the loss of high quality eggs. The receptivity of the uterus is not decreased. This age-related loss of fertility magnifies the impact of any other infertility factor(s) present.



AGING AND FEMALE FERTILITY POTENTIAL

Of the three primary factors playing a role in human conception (egg quality, sperm quality and the function of Fallopian tubes), egg quality is the most crucial in determining the probability of a live birth. It is the quality of eggs within the ovaries, rather than the receptivity of the uterus, that determines female fertility potential.

Female fertility begins to decline many years prior to menopause despite continued regular menstrual cycles. The probability of a live birth decreases 3-5% per year after the age of 30 and at an even faster rate after the age of 40. Unfortunately, as women age they also have a higher miscarriage rate.

The decreased probability of a pregnancy is due to the normal changes which occur in the woman's ovaries with aging. Most women have about 600,000 eggs in their ovaries at puberty. For each egg that matures and ovulates during a menstrual cycle, at least 500 to 1000 do not fully mature and are reabsorbed by the body.

As a woman ages, the remaining eggs in her ovaries also age, rendering them less capable of fertilization and of being able to develop into normal embryos. In addition, fertilization of these eggs is associated with a higher risk of genetic disorders. Fortunately, the vast majority of genetically abnormal pregnancies end very early, often resembling a normal menstrual period.

It is now possible to genetically test early embryos (PGD: Pre-implantation Genetic Diagnosis) as a part of In Vitro Fertilization treatment and minimize the likelihood of transferring genetically abnormal embryos into the uterus.

Risk of Chromosomal Abnormality in Newborns by Maternal Age

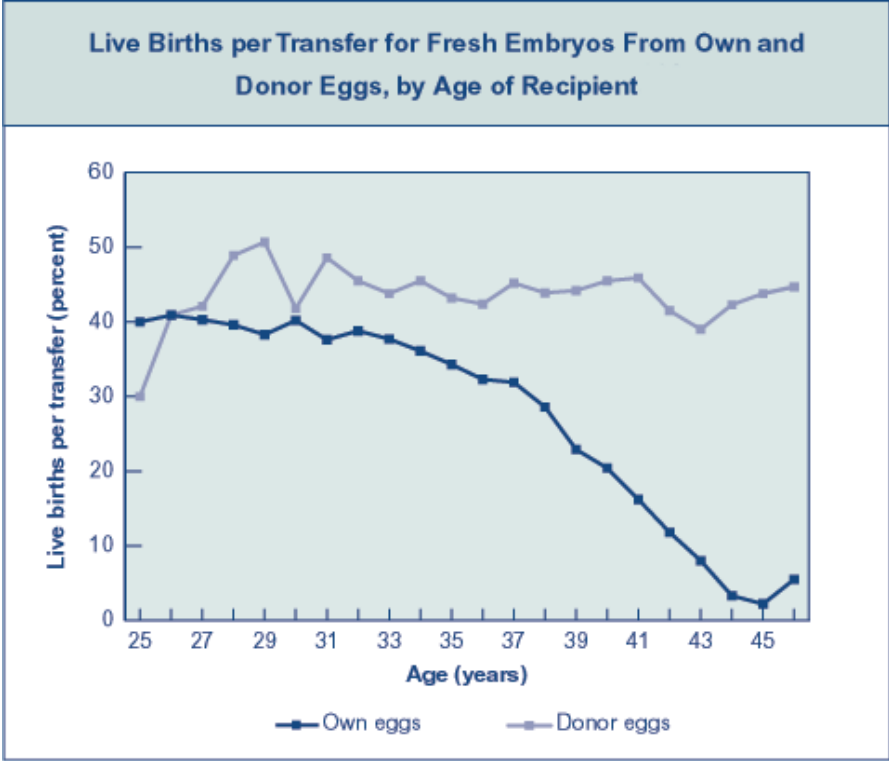
Maternal Age (years)	Risk of Chromosomal Abnormalities
20	1/526
25	1/476
30	1/385
35	1/192
40	1/66
41	1/53
42	1/42
43	1/33
44	1/26
45	1/21

Even with advanced infertility treatments, such as In Vitro Fertilization which is among the most powerful techniques to help infertile couples conceive, fertility decreases and the chance of miscarriage increases with advancing female age.

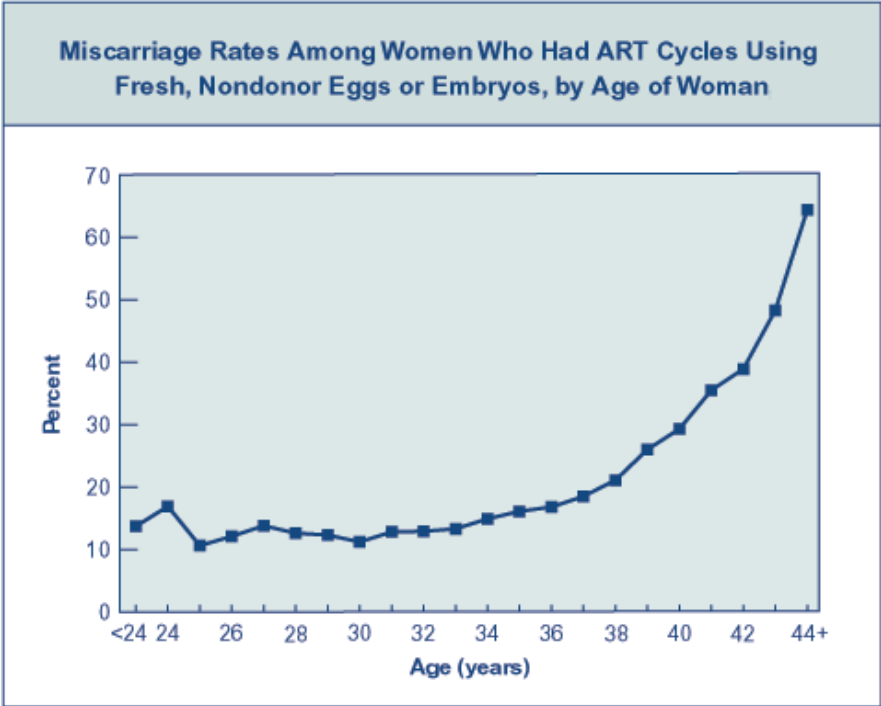
The following illustrations, from the Center for Disease Control (CDC) compilation of national IVF and oocyte donation data, show the impact of female age on the female fertility potential.

Please note that these graphs represent the nation-wide statistic; the live birth probabilities at Nova are higher.

Many infertility specialists recommend that women over the age of approximately 38 years, who are trying to conceive, should have aggressive treatment and proceed to In Vitro Fertilization quickly before their remaining fertility potential is lost.



IVF live birth rates begin to decline in the early thirties and are very low in the early forties. The likelihood of a fertilized egg implanting is related to the age of the woman who produced the egg and not to the receptivity of the uterus. Egg donors are typically in their twenties, thus the live birth rate for egg donation treatment varies only slightly across all age groups of the recipients.



This graph shows that a woman’s age also affects her risk for miscarriage. The rates begin to increase among women in their mid-to-late thirties and continue to increase with age, reaching 43% at age 42 years. The miscarriage rates observed among women undergoing ART (Assisted Reproductive Technologies, i.e. IVF) procedures appear to be no higher than in pregnancies conceived through intercourse.



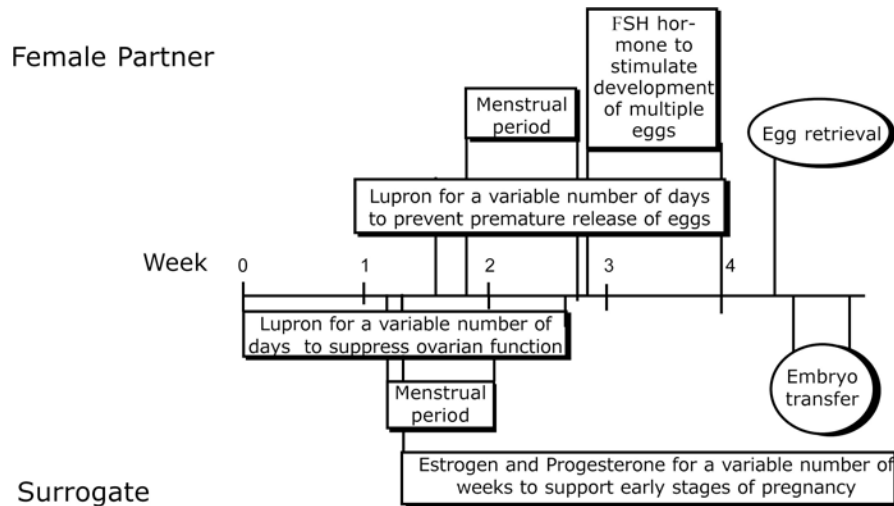
## Gestational Surrogacy

In gestational surrogacy, the intended mother provides the eggs, the intended father provides the sperm and *in vitro* fertilization is done to create embryos. The embryos are then transferred into the surrogate's uterus.

Gestational surrogacy consists of:

1. Ovarian stimulation to induce growth of multiple eggs within the intended mother's ovaries.
2. Ultrasound guided retrieval of the eggs.
3. Fertilization of the eggs with the intended father's semen.
4. Preparation of the surrogate's uterus for embryo transfer.
5. Embryo transfer.
6. Establishment of pregnancy.

This is an example of a gestational surrogacy treatment sequence. Actual treatment is individualized.



### 1. Ovarian stimulation

Gestational surrogacy treatment begins with the onset of the intended mother's menstrual period. Oral contraceptives are started within the first seven days of her menstrual cycle. They prime the ovaries for an optimal response. One week before the estimated onset of the next menstrual period, leuprolide (Lupron) injections begin. Leuprolide prevents premature release of the eggs from the ovaries prior to the egg retrieval procedure. The leuprolide injections are given subcutaneously (just under the skin). They are administered for approximately three to four weeks.

After one to two weeks of taking leuprolide, the intended mother will start her menstrual period. Within one to two weeks of the onset of this period, she begins taking follicle stimulating hormone (FSH) injections in addition to the leuprolide.

FSH stimulates maturation of multiple eggs within the ovaries. The FSH medication is taken for approximately ten days. During this time her progress is monitored by ultrasound and estrogen blood levels.

Once the eggs are ready, she is instructed to stop taking the leuprolide and FSH and to take a single injection of human chorionic gonadotropin (HCG) hormone. This is also a subcutaneous injection. This medication triggers the final stages of egg maturation. Thirty-six hours after the HCG injection, the eggs are nonsurgically retrieved from the ovaries.

## 2. Ultrasound guided transvaginal egg retrieval

Using ultrasound guidance, a tip of a thin needle is passed through the top of the vagina and into the cul-de-sac (a space behind the uterus). The ovaries are located near the bottom of the cul-de-sac allowing the tip of the aspirating needle to enter the ovarian follicles and aspirate the follicular fluid from them. The fluid is examined under a microscope to identify the eggs.

The egg retrieval takes approximately five to ten minutes. Medications are used for pain relief. Many women do not feel the eggs being aspirated. It is possible to feel a short lasting menstrual-like cramping sensation when the needle passes through the top of the vagina (once for each ovary). The actual follicle aspiration is typically not felt by the patient. The egg retrieval is a very safe procedure. The egg retrieval procedure is the last step in the intended mother's participation in the treatment. She will have her normal menstrual period within two weeks of the egg retrieval.

## 3. Laboratory

On average, eight to fourteen eggs are aspirated. The eggs are identified under the microscope and are placed into culture medium filled petri dishes. The composition of the medium resembles the fluid secreted by the Fallopian tubes. This allows the eggs and embryos (fertilized eggs) to develop in the laboratory environment at the same rate as inside the Fallopian tubes.

The intended father collects a semen specimen by masturbation on the day of the egg retrieval. The highest quality sperm are extracted from the semen and are combined with the eggs six hours after the egg retrieval. The process of fertilization takes place over a period of several hours during the night.

If the fertility history suggests a possibility of male infertility significant enough to keep the eggs from being fertilized this way, intracytoplasmic sperm injection (ICSI) is performed. In ICSI a single sperm is inserted into an egg. This can significantly increase the fertilization rate for selected couples.

Evidence of fertilization can be seen the next day, 14 to 16 hours after insemination. The fertilized eggs are transferred into growth medium and continue to be cultured in the IVF laboratory.

## 4. Preparation of the surrogate's uterus

The lining of the surrogate's uterus must be prepared to receive the embryos. The development of the uterine lining must be accurately synchronized with the development of the embryos. This is achieved by taking estrogen and progesterone.

The surrogate's treatment typically starts with taking oral contraceptives. They are used to suppress her ovarian function and to begin the process of synchronization. Oral contraceptives are started within the first seven days of the menstrual cycle.

A week before the estimated onset of the next menstrual period, leuprolide injections begin. Leuprolide "puts the surrogate's ovaries to sleep" and temporarily stops their production of estrogen and progesterone. This estrogen and progesterone secretion by the ovaries would interfere with the development of the endometrial lining.

After one to two weeks of taking leuprolide, the surrogate will have a menstrual period. Within one to three weeks of the onset of her period, she begins taking estrogen by way of medicated skin patches. The progress of the development of her uterine lining is monitored with ultrasound examinations and by estrogen blood levels. Once the intended mother is ready for the oocyte retrieval, the surrogate begins adding progesterone to the estrogen. The addition of progesterone opens the "window of receptivity" for her uterus and synchronizes development of its lining with the development of the embryos.

## 5. Embryo transfer

The embryo transfer is done one to five days after the egg retrieval. The embryo(s) is/are "loaded" into the tip of a very thin transfer catheter in a very small volume of transfer medium. The catheter is then passed through the cervical canal to within 5 mm of the top of the uterus and the embryos are gently released. The transfer usually takes a few seconds to complete. No resting is required afterwards and the surrogate can immediately resume her normal daily activities. She does not have to change her lifestyle as she goes through the surrogacy treatment.

The gamete embryologists assess the embryos prior to the embryo transfer to determine their likelihood of implantation. Most intended parents and surrogates usually select one to three embryos for the transfer. Approximately one-third to one-half of oocyte donation pregnancies are twins and there are very few triplet or higher order pregnancies.

There may be more embryos than the intended parents and the surrogate wish to have transferred. It is possible to cryopreserve these embryos and store them in liquid nitrogen.

Approximately one-half to three-quarters of the embryos survive the cryopreservation and thawing process. The implantation rate of the surviving embryos can be somewhat lower than with the "fresh" embryos.

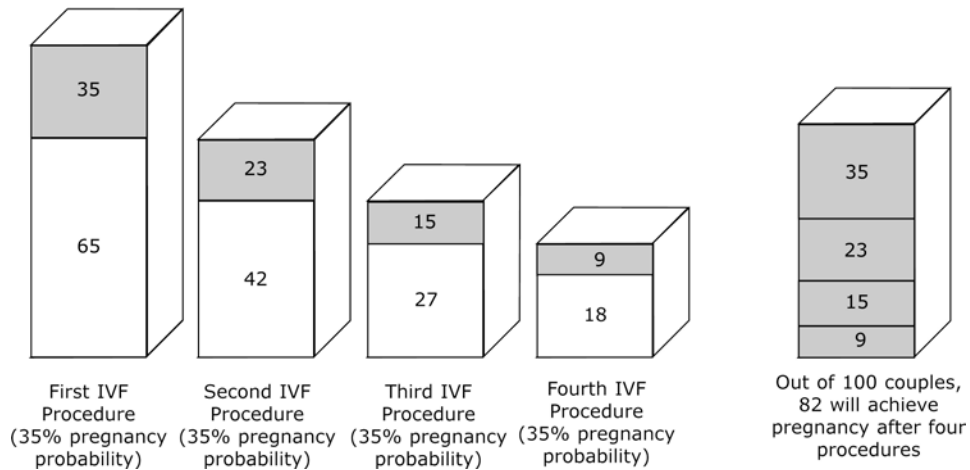
## 6. Establishment of pregnancy

After the embryo transfer, the front and back walls of the uterus gently hold the embryos keeping them within the uterus. There is no need to restrict surrogate's physical activity. She continues taking the estrogen patches and vaginal progesterone capsules or cream.

A blood pregnancy test is done approximately two weeks after the embryo transfer. If the pregnancy test is positive, an ultrasound examination is scheduled two weeks later to visualize the implantation site and to look for a heartbeat. Once a heartbeat is seen, there is a 90% to 95% probability that the pregnancy will continue to a live birth.

The surrogate continues to have her estrogen and progesterone blood levels monitored every one to two weeks. Six to eight weeks into the pregnancy the placenta produces so much of its own estrogen and progesterone that the supplementation can be discontinued. The surrogate's treatment at Nova IVF usually ends at that point and she will be referred for routine obstetrical care. Once she discontinues all medications, her pregnancy becomes indistinguishable from a pregnancy conceived through intercourse.

The following graph shows how the cumulative probability of pregnancy adds up if a couple is going through one to four cycles of IVF. In this example, we used an arbitrary 35% live birth probability per treatment. Your actual likelihood of a live birth could be higher or lower.





N o v a I n V i t r o F e r t i l i z a t i o n

## Prerequisites Gestational Surrogacy

There are very few prerequisites needed. You could complete them within a couple of weeks and be ready to start your treatment cycle.

It may be possible to reduce the cost of your prerequisites by combining two or more prerequisites into a single office visit at Nova IVF. The prerequisites are usually considered a diagnostic part of the treatment and many times your insurance company may cover a portion or most of the cost. Some prerequisites can be done by your regular OB/GYN.

Once you have had your initial consultation, you will need to complete the following prerequisites:

### Physical Examination (intended mother, intended father and surrogate)

Intended mother has a brief physical examination done together with a pelvic ultrasound. These are ideally done at the time of the initial consultation to reduce the treatment cost. A brief intended father's physical examination is done prior to semen evaluation. Surrogate's physical examination with an ultrasound and measurement of the uterus size is done at the time of her initial visit.

### Pathogen Testing

This testing is required by the State of California and FDA. You, your partner and your surrogate must be tested for several pathogens including Hepatitis B-Surface Antigen, Hepatitis C-Antibody, HIV I&II, HTLV I&II, RPR, Chlamydia and Gonorrhea. Some of these tests do not need to be repeated if done within the last 12 months.

### Reproductive Hormone Assay (intended mother)

Egg quality can vary in each menstrual cycle. Your treatment should not be started during a cycle in which there is no probability of a live birth or in which the probability is low. The reproductive hormone assay (RHA) can assess the likelihood that normal eggs will be produced.

Follicle stimulating hormone (FSH) and estrogen blood levels are measured in the RHA. FSH stimulates the ovaries to produce eggs. If the ovaries cannot produce normal eggs, the FSH level increases. Estrogen production by the ovaries influences the FSH secretion and is also related to the quality of the eggs.

Most women will have a normal reproductive hormone assay result. An abnormal result does not mean absolutely that you cannot get pregnant with your own eggs and we typically recommend repeating the test up to three times.

### Sonohysterogram (surrogate)

If your surrogate has not had a recent hysterosalpingogram (HSG, X-ray dye study of the uterus and the Fallopian tubes), a hysteroscopy or a sonohysterography, she will need to have a sonohysterogram (ultrasound) to assess the endometrial cavity of her uterus. Presence of polyps, fibroids or scarring inside the uterus can significantly reduce the probability of implantation. If any polyps, fibroids or scarring are found, their removal would require a simple outpatient procedure by her OB/GYN or a specialist.

### Trial of Endometrial Lining Stimulation (surrogate)

Your surrogate's endometrial lining must be stimulated to assess its response to estrogen administration. The endometrial response will determine the optimal stimulation of surrogate's endometrium for embryo implantation. She will be taking estrogen in the form of skin patches. We will measure her blood estrogen level and use ultrasound to assess the development of her endometrial lining.

### Semen Evaluation

The intended father must have a semen test done at Nova IVF to determine the best laboratory method of fertilization.

If you need any clarification or additional information, please give us a call or email us.

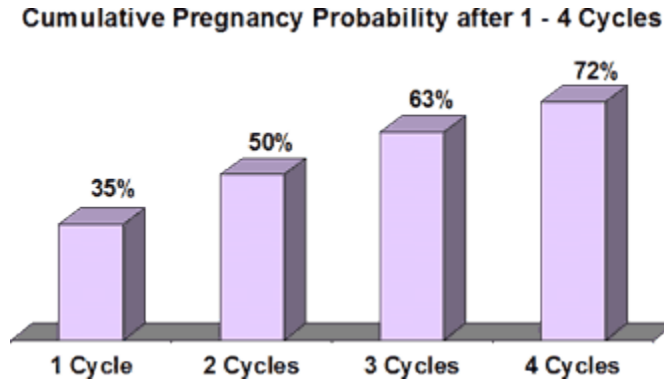


N o v a I n V i t r o F e r t i l i z a t i o n

Treatment Fees  
Gestational Surrogacy

Gestational surrogacy treatment fee structure at Nova IVF was designed to maximize the affordability of gestational surrogacy and, hopefully, maximize the probability of your successful outcome.

Having more than one cycle of gestational surrogacy treatment significantly increases the likelihood of a successful outcome. The following graph illustrates the increase in live birth probability if you decide to have more than one cycle of treatment. In this example, we used an arbitrary 35% live birth probability per cycle of treatment. Your actual likelihood of a live birth could be higher or lower.



Nova IVF fees are very competitive and contain no hidden costs i.e., facility fees, anesthesia fees, room fees, processing fees etc.

We hope that our treatment plans will provide you with the broadest financial options and will emphasize our commitment to a shared goal: a baby for you!

**Gestational Surrogacy Treatment Fees**

Treatment	Age	Treatment Fee*	Anesthesia and Procedure Room Fees	Freezing and Storage of Embryos	Frozen Embryo Transfer(s)	Assisted Hatching	Hidden Costs
One Cycle	N/A	\$12,830	Included	Fee	Fee	Fee As needed	None
Two Cycle Plan	up to 35	\$19,250	Included	Included	Included	Included Cycle #2	None
	35 to 37	\$21,170					
	38 to 40	\$23,090					
	41 to 42	\$25,020					
Three Cycle Plan	up to 35	\$29,510	Included	Included	Included	Included Cycle #2-3	None
	35 to 37	\$31,430					
	38 to 40	\$33,360					
	41 to 42	\$35,280					
Four Cycle Plan	up to 35	\$37,210	Included	Included	Included	Included Cycle #2-4	None
	35 to 37	\$39,130					
	38 to 40	\$41,060					
	41 to 42	\$42,980					

\* The treatment fee does not include the cost of pre-treatment evaluation and the state-mandated prerequisites. The above fees also do not include possible costs associated with obtaining a surrogate.

Intended mother's age at the commencement of medication (FSH) to stimulate production of eggs in the first cycle is used to determine the cost of multiple cycle treatments.

## One Cycle Fee

Services covered in the one cycle fee:

- All in-cycle office visits, physician ultrasound examinations, estrogen and progesterone determinations and physician clinical monitoring required for gestational surrogacy ovarian stimulation
- Preparation of surrogate's endometrial lining to receive embryos
- One egg retrieval procedure, analgesia, use of procedure room, one embryo transfer and medical consultations related to gestational surrogacy
- Thawing of cryopreserved semen
- Preparation of semen sample(s)
- Oocyte identification, embryo culture, including possible extended culture to blastocyst and embryo transfer
- Serum pregnancy test(s)

## Two Cycle Plan

The two cycle plan provides for *up to* two gestational surrogacy treatments, assisted hatching in the second treatment cycle, embryo cryopreservation (as needed), embryo storage and thawing with subsequent assisted hatching and transfer of any of the cryopreserved embryos.

You must have normal reproductive hormone assay result to qualify for the two cycle gestational surrogacy plan. The majority of Nova IVF patients will qualify.

Services covered in the two cycle plan:

- Same as one cycle fee  
Plus
- One cryopreservation procedure of extra, non-transferred embryos (as needed)
- Storage, thawing, culture and transfer of any cryopreserved embryos (as many times as needed)
- Assisted hatching of *any* cryopreserved embryo
- Assisted hatching of non-cryopreserved embryos in the second treatment cycle
- Preparation of surrogate's endometrial lining to receive thawed embryos (as many times as needed)

Once *all fresh and* frozen embryos have been transferred, if this treatment did not result in an ongoing pregnancy, you will receive a second cycle of gestational surrogacy with the same services as outlined above.

## Three Cycle Plan

Qualifying criteria and services provided in the three cycle plan:

Same as in the two cycle gestational surrogacy treatment but once *all fresh and* frozen embryos from the second gestational surrogacy cycle have been transferred, if there is no ongoing pregnancy, you will receive a third cycle of gestational surrogacy with the same services as outlined above (including assisted hatching and cryopreservation of extra, non-transferred embryos).

## Four Cycle Plan

Qualifying criteria and services provided in the four cycle plan:

Same as in three cycle gestational surrogacy treatment but once *all fresh and* frozen embryos from the third gestational surrogacy cycle have been transferred, if there is no ongoing pregnancy, you will receive a fourth cycle of gestational surrogacy with the same services as outlined above (including assisted hatching and cryopreservation of extra, non-transferred embryos).

Please see additional information on Nova Treatments and Fees page. If you wish, you can request an initial appointment for gestational surrogacy with one of the Nova physicians.

Fees are subject to change without notice.

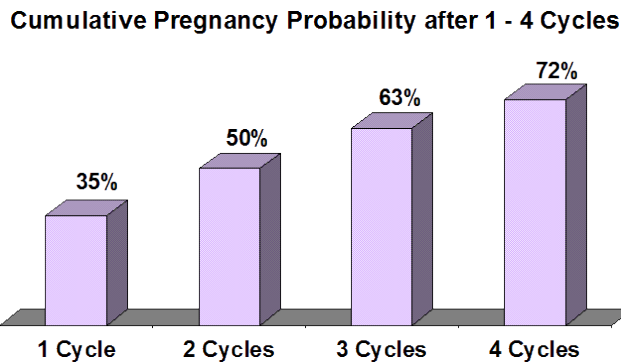


## MAXIMIZING PREGNANCY PROBABILITY

You can significantly contribute to the successful outcome of your infertility treatment. Optimizing your health and selecting a treatment plan of two or more treatment cycles can have a considerable impact on the probability of a successful pregnancy.

### Multiple Treatment Cycles

Having more than one cycle of treatment can substantially increase the likelihood of having a baby. The following graph illustrates the increase in live birth probability if you decide to have more than one cycle of treatment. In this example, we used an arbitrary 35% live birth probability per treatment. Your actual likelihood of a live birth could be higher or lower.



NOVA provides a diverse selection of very competitive multiple cycle treatment fee plans which can significantly reduce your per cycle cost.

### Optimizing Your Health

Your physical condition could make the difference between successfully achieving a live birth and going through years of frustration of unfulfilled dreams. We urge **both partners** to adhere to the following recommendations as closely as feasible and to start implementing them **as soon as possible**.

#### 1. Optimize your body's acid-alkaline balance

The pH of our blood is slightly alkaline. If we eat acidic food, our bodies have to work extra hard to keep the blood in an alkaline state. This extra work stresses our body and can lead to decrease of our fertility potential.

The choices of foods that we eat affect this balance. The typical North American diet is highly acidic. The best way to maintain the proper blood pH balance is to avoid acid producing foods and increase consumption of alkaline foods. Try not to go out to eat; prepare your own food as much as possible.

##### A. Eliminate or minimize the intake of the following acid-forming foods:

- All grains including corn, oat and flour-based foods (**bread, pasta, pastry, dumplings, tortillas, chips...**) except buckwheat and white rice up to 1 cup (cooked) a day
- Dairy (**cheese**) except milk, buttermilk, kefir and yogurt up to 1 cup a day
- Alcohol
- Coffee except de-cafeinated up to 2 cups a day
- Cocoa (use carob products instead)
- Nuts (except hazelnuts)
- Beans/legumes except up to 1 cup (cooked) a day (not canned!)
- Cranberry
- **Processed meat** (salami, sausages, hotdogs, canned meat)

**B. Increase intake of the following alkaline foods (organically grown if possible):**

- Apples
- Apricots
- Artichoke
- Asparagus
- Avocado
- **Bananas**
- **Berries** (all)
- Beets
- Bell peppers
- Bok choy
- Broccoli
- Brussel sprouts
- Cabbage
- Cantaloupe
- Carrots
- Cauliflower
- Celery
- Chard
- **Coconut**
- Cucumber
- Dates
- Eggplant
- **Figs**
- Garlic
- Ginger
- Green peas
- Grapefruit
- Grapes
- **Kale**
- Kiwi
- Lemon
- Lettuce
- Mango
- Melons (all)
- Nectarine
- Olives
- Onions
- Orange
- Papaya
- Parsley
- Peach
- Pear
- Persimmon
- Pineapple
- Potatoes
- **Raisins**
- **Spinach**
- Salad mix
- String beans
- Sweet potatoes
- Tomatoes
- Zucchini

**2. Consume an *abundance* of essential fatty acids:**

- Deep-sea fish and fish oil from non-polluted sources (<http://novaivf.com/images/pdf/Best Fish for Your Health.pdf>)
- Flaxseed and pumpkin seed oils
- Broccoli, cauliflower, beets, carrots, kale, collards, cabbage and brussel sprouts
- Raw seeds
- Eggs (no more than one a day on average)

**3. Eliminate or minimize intake of trans fatty acids (very important):**

- Fried foods (if you must have occasional fried food, use coconut oil only)
- Vegetable shortening
- Margarine
- Lard
- Animal fat
- Hydrogenated vegetable oils
- Junk food

**4. Vitamins**

Take high-potency, high-quality natural multivitamins and mineral supplements (both partners-very important). Take a minimum of 1mg of Folic Acid daily.

**5. Exercise**

Unless you exercise regularly, several times a week, start daily walks (outdoors!) for a minimum of 45 minutes each.

**6. Volatile Organic Compounds (VOC)**

Many everyday products off-gas VOC's. It is very important to minimize your exposure (both partners) to VOC's:

- Petroleum products (avoid car exhaust fumes and solvents, use disposable gloves when filling up your car)
- Off-gassing from plastics and building materials (do not drive a new car when trying to conceive, do not remodel your home or buy a newly constructed house)
- No exposure to cigarette smoke (both partners)
- Eliminate or minimize use of perfumes and colognes (unscented deodorant is ok)
- Do not dry-clean your clothes
- Eliminate air fresheners at home and in your car(s)
- Consider purchasing a VOC-scrubbing air purifier for your bedroom if you sleep with the windows closed (search internet for "voc air purifier")

**7. Stress**

Get plenty of sleep and try to minimize your everyday stresses.

**8. Acupuncture**

It is ok to have acupuncture

**9. Chinese medicine**

It is ok to use Chinese herbs as long as they are for strengthening your health only and do not have any female hormone-like effect.



## Gestational Surrogacy Agencies

There are many gestational surrogacy agencies, several of them in the Bay Area. Each of them has a pool of pre-screened surrogates from which you can make your selection. The surrogacy applicants are typically young women in their twenties and thirties with low risk for disease transmission and substance abuse. Most of them have made the decision to become a surrogate based on a combination of the financial incentive and an altruistic need to help infertile couples.

Once you have selected your surrogate, she will be instructed by the agency to contact us directly to set up her initial consultation at Nova IVF.

We work with many surrogacy agencies. You could find an agency on your own or you can choose one of the following agencies we are most familiar with:

### **Conceptual Options**

12780 Danielson Ct., Suite B  
Poway, CA 92064

858-748-4222

[ConceptualOptions.com](http://ConceptualOptions.com)

### **Creative Conceptions**

23832 Rockfield Blvd. Suite 255  
Lake Forest, CA 92630

949-597-3191

[creativeconceptioninc.com](http://creativeconceptioninc.com)

### **Everything Surrogacy.com**

This is a website with an extensive list of surrogacy agencies

[EverythingSurrogacy.com](http://EverythingSurrogacy.com)

### **Family Formation**

3190 Old Tunnel Road  
Lafayette, CA 94549

925-945-1880

[lodm.com](http://lodm.com)

### **Loving Donation**

522 Hunt Club Blvd. Suite 325  
Apopka, FL 32703

800-749-5773

407-682-6604

[LovingDonation.com](http://LovingDonation.com)

### **Miracles Egg Donation**

P.O. Box 2298  
Glendora, CA 91741

626-260-0467

[MiraclesInc.net](http://MiraclesInc.net)

### **Nation Wide Egg Donation**

P.O. Box 6277  
Boise, ID 83707

208-573-7309

[NationwideEggDonation.com](http://NationwideEggDonation.com)

### **Surrogate Alternatives**

363 Calle La Quinta  
Chula Vista, CA 91914

619-397-0757

[SurrogateAlternatives.com](http://SurrogateAlternatives.com)

### **The Donor Source**

4675 MacArthur Court, Suite 490  
Newport Beach, CA 92660

877-375-8888

310-791-0367

[TheDonorSource.com](http://TheDonorSource.com)

### **The Egg Donor Program**

4727 Wilshire Blvd., Suite 600  
Los Angeles, CA 90010

323-933-0414

[EggDonation.com](http://EggDonation.com)

### **Woman to Woman Fertility Center**

3201 Danville Blvd., Suite 160  
Alamo, CA 94507

925-820-9495

[WomanToWomanFertilityCenter.com](http://WomanToWomanFertilityCenter.com)

### **X and Y Consulting**

2250 East Palmyra Ave.  
Phoenix, AZ 85020

602-678-1906

[EggDonorsNow.com](http://EggDonorsNow.com)

## Gestational Surrogacy: Guidelines

### Deciding about Gestational Surrogacy

Please consider the following questions before finalizing your decision to proceed with the surrogacy treatment:

- Why is Gestational Surrogacy a better option for you and your partner than egg donation or child-free living? Do you understand the difference between gestational and traditional surrogacy?
- Have you discussed using a surrogate with your family? Why or why not? What were their reactions?
- Who will you tell about your child's background and when?
- Have you determined if you will tell your child about his/her background? If so, when? If so, how will you tell your child? Perhaps share pictures and family history about your surrogate?
- Have you considered how you might feel if, after all the interaction and sharing with a surrogate, she does not get pregnant?
- Have you and your partner discussed theoretically the number of embryos to be transferred? Are you aware that a greater number of embryos transferred results in higher rates of multiple pregnancy?
- Do you know what selective termination or selective reduction means? How do you feel about it? Do you know the risks of miscarriage from multiple pregnancies versus the risks of miscarriage from selective termination?
- Have you considered how you would feel if the child is born with a birth defect?
- Is there an egg quality and/or a male factor as well?

### How to Choose a Gestational Surrogacy Agency

You may look for a surrogate on your own or you may use the services of a third party gestational surrogacy agency. Here are some common guidelines and questions:

- What is the fee schedule for the provider's services? Do you have to pay a fee up front? Is the fee refundable if you change your mind about a surrogate? What exactly do all the fees cover? Does the agency charge differently if you pay cash, check or credit card?
- What is the fee for the surrogate herself? Can she set her reimbursement herself? If she was a surrogate before has her price remained the same or gone up? If the intended parents pay the surrogate's expenses, does the agency provide an itemized list of expenses?
- What kind of screening does the surrogate need to have? What is the psychological screening and who performs it, the agency or a third party? Is there an extra charge for psychological testing (i.e. MMPI)? Can you see the results of the testing? Can you have the surrogate tested by a third party of your own choosing?
- Does the agency facilitate a meeting between you and the surrogate?
- What kinds of records and information are kept on surrogates, where and for how long? There may be some reason in the future to contact your surrogate.
- What is the legal contract the agency requires the surrogate to sign?
- How long has the agency been in business under the current name or a different name? How many surrogates has the agency matched with the intended parents in a year?
- Does the gestational surrogacy agency help the uninsured surrogate find medical coverage?

## Finding a Surrogate on Your Own

A surrogate can be a relative, friend, or you may want to find a surrogate on your own, rather than using a gestational surrogacy agency.

A blood-related surrogate can be an excellent choice as long as the potential surrogate is not pressured into the treatment. Also consider what would happen to the family relationships if the treatment was unsuccessful. The feeling of guilt and "letting you down" by the surrogate may be profound.

Once you select a potential surrogate, have her email or call us to set up her initial consultation.

Your surrogate does not have to live locally or even in this country. It is possible to minimize the number of your surrogate's visits to Nova IVF. She would have to come for a 1 to 2 day visit prior to the beginning of the gestational surrogacy cycle and would have to stay for a day during the treatment itself.

We have listed some of the factors you should consider in your search for a qualified gestational surrogate:

Positive Indicators:

- Younger than 40 years of age
- History of at least one full-term pregnancy
- History of regular menstrual periods
- No history of infertility or multiple miscarriages

Negative Indicators:

- Positive family history for inheritable psychiatric disorder
- Substance abuse
- Two or more first degree relatives with substance dependence
- Current use of psychotropic medications
- Family history of sexual or physical abuse without professional treatment for the surrogate
- Chaotic lifestyle
- Significant current stress
- Marital relationship instability
- History of legal difficulties
- High risk sexual practices
- Under the age of 21
- Desperate financial situation
- Objection to gestational surrogacy by the partner of a potential surrogate should disqualify such surrogate.

## Questions to Ask Potential Gestational Surrogates

Please consider the following questions in making your surrogate selection. The choice of the questions will depend on whether the potential surrogate is a relative or friend, or merely a known surrogate.

#### General Questions:

- Why do you want to participate in gestational surrogacy?
- What are your feelings about being available in the future for the baby?
- What are your expectations about how a child born from this treatment should be raised?
- Does it matter if the intended parents are married?
- Does it matter if I (as the intended parent) am single, a gay or a lesbian?
- What do you imagine how you will feel if the procedure does not succeed?
- Do you expect any legal relationship with the baby?
- What are your expectations, if any, around receiving a fee for your participation?
- Are you willing to participate a second time if we desire siblings for our child, or if a pregnancy didn't result from the first transfer?
- Do you have any children of your own? How many do you have and what are their ages?
- Are you willing to participate in a counseling session?
- Are you aware that you will need to sign a legal agreement detailing your willingness to sacrifice all parental claim or responsibility?
- Do you have health insurance in the event of pregnancy complications?
- If you have a husband/partner, how does he feel about your interest in gestational surrogacy?
- What is your understanding of the medical procedure needed to prepare your uterus to receive the embryo(s)?
- Who will be your support person during the treatment? Who will give you your injections?
- Are you aware that there may be a multiple pregnancy? How do you feel about this possibility?
- Are there people with whom you have shared your interest to be a surrogate? If there were any, what were their reactions?
- Why do you think you would be a good surrogate?
- What do you believe your strengths and weaknesses are?
- Do you have any ethical or religious viewpoints which might affect your decision to be an surrogate?
- Do you know anyone who has been a surrogate? What was her experience?
- Where did you learn about this opportunity?
- What are your feelings about selective termination or selective reduction?
- Are you willing to have an amniocentesis or chorionic villi sampling if recommended by your obstetrician?

#### Specific Questions When the Surrogate Is a Relative or a Close Friend:

It is presumed that any surrogate who is a relative or a close friend will have an ongoing or close relationship with the intended parents. Consequently, the questions do not need to be as expansive as with a recruited surrogate.

- Is there anything significant about your relationship with your relative that contributed to your decision to be a surrogate?
- What do you imagine are the concerns associated with being a surrogate to a relative?
- How do you imagine your relationship will change by being a surrogate?
- How does your family feel about your decision to be a surrogate to a relative?
- Who will know about this decision and who will not?
- If you have decided to keep this private, how do you expect to handle an unplanned disclosure?
- If you have a husband or partner, how does he feel about the possibility of a baby born of this procedure? Will he participate in counseling if requested?
- Have you discussed with your partner the risks associated with this procedure and with the medication you must take?

Specific Questions for an Unrelated Gestational Surrogate:

- Have you or any member of your immediate family ever smoked, drank or used illegal substances? To what extent are any of these, or have any of these ever been, a problem?
- Have you ever been pregnant? What was the outcome?
- Have you ever been a surrogate before? If you have, was there a resulting pregnancy, multiple pregnancy, and live birth(s)?
- Do you have any children? If yes, how old are they now? Were there and are there any significant health issues we should know about? What was their birth weight and length?
- If you do not have children, why do you want to help us have a baby? Have you considered the unlikely circumstance where at a later date you might be unable to conceive?
- Why do you want to be a surrogate? What do you think you will get out of it? If you have already been a surrogate, what did you get out of it?
- If you get pregnant, will you tell your family members including your children that this is a gestational surrogacy pregnancy? If so, how will you tell them, and when?
- Have you thought about how you would feel if, after all this interaction and sharing, you do not get pregnant?
- Have you thought about whether you would like any ongoing contact such as pictures, phone calls or meeting the child?
- Is your job or school situation flexible enough to do this procedure? Do you have child care available, if you have children?