BSSI
PATIENT INFORMATION SHEET

Name_____ Phone (Cell) _____

Address_____ Phone (W) (H) _____

_____ Age_____ DOB_____
City State Zip
Email address_____

Have you been our patient before? _____ Social Security#_____

Who referred you to our office? ☐ Friend/Relative ☐WEN/NAF Other:_____

Your Doctor? ☐Dr.'s Name_____ ☐Internet Other? _____
Your Pharmacy Name:_____ Phone number or Cross Streets:_____

Emergency Contact: #1_____Relationship_____ Phone_____
Driver Name and Phone, if different from above: Name_____Phone_____
Emergency Contact #2_____Relationship_____Phone_____

Please Initial) _____ I authorize BSS International Inc., hereinafter referred to as BSSI, its physicians, and staff to speak to my emergency contacts and/or driver. If for any reason BSSI, its physicians and staff, or any entity acting on their behalf attempt to contact me and are unable to do so, I authorize the contacting of myself or any of my emergency contacts via telephone or postal mailing address provided. This includes any and all attempts at debt collecting.

_____

PLEASE CHOOSE **ONE** OPTION. INITIAL **ONE** ONLY

Failure to disclose this information today will result in waiver of insurance claim and monetary refund.

PLEASE COMPLETE THIS SECTION IF **YOU HAVE <u>NO HEALTH INSURANCE</u>:**

_____I am hereby stating that I am currently uninsured. I have no active medical health insurance coverage or any pending medical/health insurance, which may have a retroactive effective date resulting in active coverage for today. I agree that it is my full responsibility and obligation to inform the office staff of my true and accurate insurance status PRIOR to any medical care I receive today, or in the future. I understand that no insurance claims will be filed by this office or myself due to my failure to provide true and accurate insurance coverage information, AND HAVE NOT PROVIDED ACCURATE INSURANCE COVERAGE INFORMATION IN WRITING prior TO SERVICES BEING RENDERED UPON ME.

OR

PLEASE COMPLETE THIS SECTION IF **<u>YOU HAVE HEALTH INSURANCE BUT ARE NOT USING IT TODAY</u>**

_____Due to the sensitive nature of the services provided, I hereby request to waive all of my rights to file an insurance claim. BSSI, will not accept assignment for medical care provided to/upon me, BSSI or any member of his medical staff. I have been advised that today's medical service may be a benefit covered by my current health insurance. I choose to pay for it, and all associated medical costs in full, prior to the services being rendered. I do not want this office to contact my insurance provider or furnish them with any information. This decision is irrevocable.

OR

PLEASE COMPLETE THIS SECTION IF **<u>YOU HAVE INSURANCE AND ARE USING IT HERE TODAY</u>**

_____In consideration of services rendered hereby irrevocably assigned transfer to BSSI, all rights, title and interest on the benefits payable for services rendered by BSSI or his agents provided in the above mentioned policy. I hereby authorize the insurance company herein listed above to pay directly to BSSI, all benefits due under said policy (ies) by reason of services rendered therein. I will pay BSSI, for all charges incurred or alternatively for all charges in excess of the sums actually paid pursuant to said policy (ies) A Photostat copy of this authorization shall be as valid as the original.

Insurance Co: _____ ID#_____ Group_____
Insured's Name: _____ Relationship to Patient: _____ Date of Birth_____

TO BE COMPLETED AND SIGNED WITH THE PATIENT EDUCATOR

☐ *MEDICAL* ☐ *1ST TRIMESTER* ☐ *D&E*

Options Explained
Informed Consent
Anesthesia Risks, Benefits and Side Effects Explained
Follow-Up Appointment and Post-Op Instructions given
Discussed STDs, HIV
D/V Screening
Patient comfortable with 1st Trimester medical/surgical abortion procedure
After 15 weeks LMP
Pt comfortable with 2nd Trimester Procedure
Laminaria Consent/Laminaria Instructions
Caregiver's correct phone number given
Phone number where patient may be reached during the night:

*Birth Control Discussed, Patient chose*_____
*Information Given*_____*Samples*_____
☐ *FM* ☐ *FD*
Notes: _____
_____
_____
_____

I have answered all questions to the best of my knowledge and have discussed the procedure, sedation, risks, complications benefits and side effects with the advocate. I confirm I did not have anything to eat or drink since _____. I understand that it is my responsibility to have someone drive me home after surgery, and stay with me 24 hours, if I choose anesthesia.

Patient Signature_____ Date_____
Patient Educator Signature_____ Date_____

MEDICAL HISTORY

Your answers are for our records and will be considered confidential

Name_____ Date of Birth_____ DATE_____

Pregnancy History

Prior Pregnancies_____ Number of living children_____

Full Term_____ Premature_____ Vaginal Births_____ Cesarean_____ Miscarriages_____ Abortions_____

Ectopic Pregnancies_____ Molar Pregnancies_____ Other Complications_____

Date of Last Menstrual Period_____ Your Blood Type (if known) _____ ☐ Positive ☐ Negative

Gynecological History

(Please check any you have now or had in the past)

☐History of STD's: ☐Gonorrhea ☐Chlamydia ☐Trichomonas ☐Syphilis ☐Herpes ☐HIV ☐HPV

☐History of Abnormal Paps ☐Colposcopy ☐Cryosurgery ☐Leep/Cone Biopsy ☐Fibroids ☐Abnormality

General Health Questions

Are you in good health?..... ☐YES ☐NO_____

Conditions presently being treated _____, _____, _____

List previous surgeries (and year): _____, _____, _____

Other hospitalizations_____

Have you had any abnormal bleeding associated with previous surgery or trauma: ☐YES ☐NO

Previous blood transfusions: _____

ALLERGIES to any drug or substance ☐YES ☐NO List any and all substances to which you are allergic:

_____

Have you or any family member has history of medical condition ☐YES ☐NO (Who) _____and What?_____

Are you taking any medications at this time ☐NO ☐YES **(Please List)**_____

_____ _____ _____ _____

Do you smoke? ☐YES ☐NO Substance Abuse? ☐YES ☐NO (Type) _____

Please Indicate Yes or NO for any Conditions even if you no longer have them.

	YES	NO		YES	NO		YES	NO
Heart Disease.....	☐	☐	Hepatitis.....	☐	☐	Tumors/Growths.....	☐	☐
Heart Murmur.....	☐	☐	Diabetes.....	☐	☐	Infections.....	☐	☐
Mitral Valve Prolapse.....	☐	☐	Asthma.....	☐	☐	Swollen Lymph Glands	☐	☐
Congenital Heart Defects	☐	☐	Shortness of Breath..	☐	☐	Emotional Problems....	☐	☐
Rheumatic Fever	☐	☐	Lung Disease.....	☐	☐	Anxiety.....	☐	☐
Heart Attack.....	☐	☐	Tuberculosis.....	☐	☐	Psychiatric Care.....	☐	☐
Pacemaker.....	☐	☐	Emphysema.....	☐	☐	Frequent Headaches	☐	☐
Stroke.....	☐	☐	Liver Disease.....	☐	☐	Sinus Trouble.....	☐	☐
High Blood Pressure....	☐	☐	Seizures.....	☐	☐	Hives/Rash.....	☐	☐
Low Blood Pressure.....	☐	☐	Ulcers.....	☐	☐	Thyroid Disorder.....	☐	☐
Scarlet Fever.....	☐	☐	Kidney Disease.....	☐	☐	Epilepsy.....	☐	☐
Chest Pain	☐	☐	Anemia.....	☐	☐	Cancer Treatment.....	☐	☐

Is there any condition or problem that you think we should know about? ☐YES ☐NO If yes, explain:

_____

I have read (or have had read to me) the foregoing evaluation and I certify that the information provided above is correct to the best of my knowledge.

SIGNED BY PATIENT: _____ DATE: _____

The Following To Be Completed By First and Second Trimester Surgical Patients ONLY:

In accordance with Section 383.33625 of the Florida Statutes, all remains will be handled and disposed of according to its guidelines. Your signature below authorizes our physicians to dispose of fetal remains under the terms customarily used.

_____ I HAVE READ THIS NOTICE. I WILL NOT BE MAKING ANY ARRANGEMENTS WITH A FUNERAL HOME.

IF YOU INTEND TO HAVE ARRANGEMENTS MADE WITH A FUNERAL HOME, THESE ARRANGEMENTS MUST BE MADE IN ADVANCE, BY YOU. IT IS YOUR RESPONSIBILITY TO COORDINATE WITH THEM, AND TO NOTIFY OUR OFFICE OF YOUR INTENTIONS, AS WELL AS TO PROVIDE US WITH THEIR CONTACT INFORMATION. PLEASE INITIAL IF YOU ARE DOING SO.

_____ I HAVE MADE ARRANGEMENTS WITH (Name and Phone of Funeral Home): _____

For More Information or to Report a Complaint

If you have questions or want to report a complaint, please contact our Privacy Officer, at (954)720-7777. Complaints may also be filed with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

I have read this privacy notice and I have been given ample time to ask questions regarding the information it contains. I understand BSSI information when authorized by me in writing, or when required by law to do so.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

Privacy Notice Acknowledgement

I acknowledge that I was provided a copy of the Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

Assigned Authorization to Release Medical & Financial Information

I, _____authorize the office of BSSI to provide complete/full access of my medical and financial information to: (Print Name of person you wish to have access to your records) _____.I understand that by completing this section and signing below, I give my permission for BSSI or any member of his staff to release my personal medical and/or financial information in writing and/or verbally to the person I have listed above. I confirm that my <u>failure to fully complete this section will void authorization</u> to release information.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

Authorization of Voice Messages Pertaining to Health Information

By signing below, I authorize BSSI or any member of its staff to provide detailed voice messages in regards to my personal health information and/or financial information at the following telephone number(s): (_____)_____, (_____)_____. I understand that by signing, I authorize that a voice message may be left at the telephone numbers above. These messages may contain but are not limited to laboratory test results, surgical outcomes and prescription/drug information.

Follow-Up Telephone Call

Under Florida Law, one of our medical staff is required to call you within 24 business hours of your appointment. However, <u>you may choose to decline this call for privacy or any other reason(s).</u>
Please **INITIAL ONE** of the following:

_____ DO NOT CALL ME.

OR

_____ I CONSENT TO A TELEPHONE CALL from BSSI or any member of its staff. The telephone number to reach me is: (_____) _____Ext: _____.
If I do not answer the telephone, no voice message is to be left and no additional attempts are to be made.
<u>(If you have caller ID, the name and phone number of BSSI will appear).</u>

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

AFFIRMATION: 18 Years of Age or Older

I hereby declare and affirm that I am **18 YEARS OF AGE OR OLDER** and therefore am not affected by the State of Florida Parental Notification Law. I understand that affirmation by providing my signature below becomes a legal document and I may be subject to criminal prosecution if provided falsely.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

MINORS ONLY (18 Years of Age or Younger): Please INITIAL ONE:

_____ I am accompanied by my parent or legal guardian
Name: _____ **Relationship:** _____

OR

_____ I have obtained **A JUDICIAL WAIVER (BYPASS)**, and will provide it.

OR

_____ I am an **EMANCIPATED MINOR** with a court order, and will provide it.

Mifeprex and Misoprostol Abortion Consent
(Please Initial)

I, _____, hereby give permission for BSSI and its designated physicians to perform a non-surgical/medical abortion with Mifeprex and Misoprostol.

_____ I have fully disclosed my complete medical history including but not limited to: the date of my last menstrual period, allergies, blood conditions, prior medications or drugs and reactions to medications or drugs. I certify that I have read this form or that it has been read to me. I understand its contents and any questions have been answered to my complete satisfaction and understanding. I certify that I have been given the Mifeprex Medication Guide and that I have had an opportunity to read it and discuss it with my provider.

_____ I understand I will be given the FDA approved protocol a 200mg dose of Mifeprex and a 600mcg dose of oral Misoprostol.

DESCRIPTION:

_____ I understand that I am fewer than 11 weeks pregnant, and I have decided to have an abortion with the medications: Mifeprex and Misoprostol. These medications will cause an abortion by starting cramping and vaginal bleeding like a heavy period or miscarriage. This method allows a pregnant woman to have a non-surgical abortion.

_____ Mifeprex is a drug which blocks the action of progesterone, a hormone needed to continue the pregnancy. Mifeprex has been approved by the U.S. Food and Drug Administration (FDA) for early abortion, and has been used by millions of women in Asia and Europe (it has been referred to as "RU-486". Misoprostol is a drug used in the United States to prevent irritation or ulcers in the stomach, in an off-label use. When the FDA approved Mifeprex, it was approved for combination with Misoprostol. Studies have shown that Mifeprex and Misoprostol, when used together, are approximately 95% effective in causing an abortion in early pregnancy.

_____ The FDA-approved regimen has the efficacy (i.e., it works 95% of the time).

PROCEDURE:

_____ The provider will take my medical history and examine me to assess how many weeks pregnant I am. An ultrasound will be done to determine how far along my pregnancy is. The ultrasound will be done by inserting the ultrasound probe into my vagina (this is called a transvaginal ultrasound). I will have my blood taken ("finger stick") to check my RH factor (positive or negative blood type) and hemoglobin (anemia).

_____ I will swallow 200mg Mifeprex (one tablet), while at this office. This will be called "Day 1".

_____ 24 hours (Twenty-four hours) later, at home, I will dissolve buchally 800mcg Misoprostol (4tablets) in my mouth as instructed.

_____ I will remain at home and plan to relax for at least the next 6 hours as this is when bleeding and cramping will likely occur. I understand that I must have access to a telephone, have been provided with 24-hour emergency contact information.

_____ I will contact my provider at (954)720-7777 (or 954-790-7770 After Hours) if: I soak 2 or more MAXI-pads per hour for 2 consecutive hours; I have a sustained fever (101.0F) or onset of fever a few days after Misoprostol; I have severe abdominal pain not helped by non-aspirin pain medicine; or I have no bleeding within 24 hours after Misoprostol was inserted, which may require more medication or an evaluation for an ectopic pregnancy (pregnancy not in the uterus).

_____ I will return to the office around day 14, as this appointment was scheduled before I ingested Mifeprex on day 1. This follow up appointment is very important to confirm that termination of my pregnancy has occurred and that there have been no complications. At this visit, I will have a transvaginal ultrasound and urine pregnancy test. If my medical abortion has occurred, then I am done.

RISKS may include:

_____ Incomplete Abortion: As with a surgical abortion, some pregnancy tissue may remain in my uterus. If this occurs, the provider will discuss my treatment options which may include waiting one or more weeks, using more Misoprostol, or having an aspiration which is similar to a surgical abortion. If I decide to wait or use more Misoprostol and the abortion is still not complete, I will need aspiration curettage. The risks of aspiration curettage include a risk of making a hole in the uterus, tearing the cervix, adverse reaction to anesthesia that may be used, infection, excessive bleeding, death and failure to remove all of the tissue from the uterus.

Mifeprex and Misoprostol Abortion Consent
(Please Initial)

_____ Vaginal Bleeding: As with the surgical abortion, heavy bleeding can occur and blood clots may come out of the vagina. If I have extremely heavy bleeding or dizziness, aspiration curettage may be necessary to stop the bleeding. The risks of the aspiration curettage are stated above. The risk of having very heavy vaginal bleeding after Mifeprex/Misoprostol is about 1 per 100 (1%). The risk of needing a blood transfusion after using Mifeprex/Misoprostol is about 1 per 1,000 (0.1%).

_____ Continued pregnancy and birth defects: My pregnancy may not end after receiving the medications. If this happens, birth defects are possible. Because of the risk of birth defects, I know that a surgical abortion is strongly recommended to end the pregnancy. I will be responsible for the cost of the surgical abortion, if the medical abortion fails. The risks of a first trimester surgical abortion include a risk of making a hole in the uterus, tearing the cervix, adverse reaction to the anesthesia that may be used, infection, excessive bleeding, death and failure to remove all the tissue from the uterus.

_____ Side effects: The following side effects are possible (10-15%): nausea, vomiting, diarrhea, fever, headaches and chills. Most of these side effects last less than a day. I will have cramping in my lower abdomen and may need pain medication for this reason.

_____ Ectopic pregnancy: A rare condition which is a complication of pregnancy rather than the abortion is an ectopic pregnancy or a pregnancy in the fallopian tube or outside the uterus. I understand that if the pregnancy is in the fallopian tube or outside the uterus, neither a surgical abortion nor a Mifeprex/Misoprostol abortion will remove the pregnancy, and due to the possible threat of rupture of the fallopian tube, hospitalization may be necessary as soon as it is discovered.

_____ Infection: There is a very rare risk of serious bacterial infection after a medical abortion. There is a 1 in 100,000 risk of developing fatal septic shock. There would be a risk of developing this infection following childbirth, miscarriage, surgical abortion or after other types of surgeries. If more than 24 hours after taking the second medicine (Misoprostol) I have severe abdominal pain or discomfort, or are "feeling sick" including weakness, nausea, vomiting or diarrhea, with or without fever, I will contact BSSI right away. If I visit an emergency room or another health care provider who does not prescribe Mifeprex, I will tell them I am undergoing a medical abortion. I understand this risk is higher than surgical abortion and accept this risk.

_____ It is unknown if antibiotic use might prevent this very rare infection. BSSI feels it could help and recommends Flagyl (generic: Metronidazole) 250mg 3 times daily for 3 days. Many providers are doing this and they will be prescribed to you to take as directed.

COSTS AND PAYMENTS:

_____ I will receive medical care for my abortion as described above (including information about birth control) at an out of pocket charge. The fee does not include my cash out of pocket responsibility for a surgical abortion if needed. The out of pocket fee does not include charges incurred for an emergency room visit, care received at a hospital, care at another facility or any unrelated medical care.

VOLUNTARY CONSENT:

_____ I have been informed of other choices during early pregnancy including continuing the pregnancy and becoming a parent, continuing the pregnancy and making adoption arrangements and surgical abortion. I have been informed of the risks involved with a surgical abortion and a medical abortion and the risks involved with continuing the pregnancy. I understand that I may choose to have a surgical abortion at any time after I start the medical abortion although I will be required to pay out of pocket for this care and that the fee for the surgical procedure is $550.00. Based on conversations with BSSI or the physician that is treating me today, and the information he has provided, I have chosen the method that is best for me.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF SIGNATURE DATE