

**ULTRASOUND ACKNOWLEDGEMENT AND INFORMED CONSENT**

I, \_\_\_\_\_, consent to have an ultrasound performed by BSSI to determine the probable gestational age of the pregnancy at the time of my termination of pregnancy. The cost of the ultrasound is \$250 and not refundable. It is applied toward the payment of the termination. **(The ultrasound image cannot be copied, duplicated, or provided.)** It is used for fetal aging only.

**(Please initial)**

\_\_\_\_\_ I understand and acknowledge that if I decide to not terminate this pregnancy, the staff and physicians of BSSI are not responsible for any further care that I may require or desire and does not constitute his/her responsibility as my attending physician.

\_\_\_\_\_ I understand and acknowledge that in accordance with Florida law, it is required that a Physician, (or other qualified person), perform an ultrasound and inform a patient seeking to terminate a pregnancy of the probable gestational age of the fetus, and be offered the opportunity to view contemporaneous ultrasound images and have them explained.

\_\_\_\_\_ I understand and acknowledge that I have the opportunity to view the ultrasound images and hear an explanation.

\_\_\_\_\_ I understand and acknowledge that in the event the pregnancy is over 13 weeks LMP (last menstrual period) and/or is a multiple gestation, I will be notified of this information.

**(Please circle either YES or NO for each of the following)**

- 1. **YES NO** I request to view the ultrasound image.
- 2. **YES NO** I request to hear an explanation of the ultrasound results.

I certify the decision to view the images or hear the explanation were not based on any undue influence from any person to discourage me from doing so. This decision was made of my own free will.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness \_\_\_\_\_  
Date

**To be signed with Authorized Medical Provider: (Please initial your choice)**

- \_\_\_\_\_ I have decided to opt out of viewing or hearing the ultrasound images.
- \_\_\_\_\_ I have received and I am satisfied with the viewing and/or explanation of the ultrasound.
- \_\_\_\_\_ "Fetal Development and Alternatives to Terminating a Pregnancy" printed materials from the Florida Department of Health have been made available to me.

**A physician orally and in person informed me of:**

- \_\_\_\_\_ The nature and risks of the abortion procedure I am considering having.
- \_\_\_\_\_ The risks of carrying to term.
- \_\_\_\_\_ The estimated gestational age of the fetus, verified by ultrasound today, and at the time of my projected appointment.
- \_\_\_\_\_ I understand that if the abortion date is postponed, I must add on each additional day to the probable gestational age of the fetus.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date

**I herby certify that I have orally and in person informed this patient of the above.  
( ) Medical Abortion ( ) Surgical Abortion ( ) Second Trimester Abortion.**

\_\_\_\_\_  
Authorized Medical Provider Signature \_\_\_\_\_  
Date

**PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_

Address: \_\_\_\_\_

Phone (W) (H): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Email address: \_\_\_\_\_

Have you been our patient before? \_\_\_\_\_ Social Security#: \_\_\_\_\_

Who referred you to our office?  Friend/Relative  WEN/NAF  Internet

Your Doctor?  Dr.'s Name: \_\_\_\_\_ 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 NO HEALTH INSURANCE:**

\_\_\_\_\_ 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 YOU HAVE HEALTH INSURANCE BUT ARE NOT USING IT TODAY**

\_\_\_\_\_ 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 its 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 YOU HAVE INSURANCE AND ARE USING IT HERE TODAY**

\_\_\_\_\_ In consideration of services rendered hereby irrevocably assigned transfer to BSSI all rights, title and interest on the benefits payable for services rendered BSSI or their 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  1<sup>ST</sup> 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 1<sup>st</sup> 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.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Lymph Glands	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath..	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches...	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>

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): \_\_\_\_\_

**BSSI**

**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 failure to fully complete this section will void authorization 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, you may choose to decline this call for privacy or any other reason(s). 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. **(If you have caller ID, the name and phone number of BSSI will appear).**

\_\_\_\_\_  
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)**

**Page 1 of 2**

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 buccally 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

**Michael J. Benjamin, MD, FACOG**  
7777 North University Drive, Suite 102  
Tamarac, FL 33321  
Hours: Monday – Friday 8:30am – 5:30pm and Saturdays 8am – 12pm  
Tel: (954) 720-7777 | Fax: (954) 726-2896

After Hours, for **Emergencies only**, call: 954-790-7770

## **Non-Surgical Mifeprex/Misoprostol Abortion Process**

**Please read these forms carefully and complete and sign all paperwork and consents prior to your examination. You must present a valid photo ID.**

After completion of the paperwork, an ultrasound evaluation will be performed for fetal dating. The non-surgical option is only available up to 10 weeks gestation, as documented from our ultrasound measurements, TODAY. Beyond 10 weeks, a surgical procedure is available through 24 weeks gestation in the state of Florida.

Once the ultrasound and your lab work is completed, the process will be fully explained, and you may begin the abortion process. If you choose to proceed, you will be provided with one (1) 200 mg. tablet of Mifeprex and a glass of water, with which to take it. This dose is taken in our office and the event will be documented. Do not consume alcohol for the following 72 hours. You will be provided with the Mifeprex medication guide. You will also be given a medication bottle containing four (4) tablets of Misoprostol to take home with you. Make plans to stay home the following day.

***Mifeprex (RU-486) Taken orally on: Date: \_\_\_\_\_ at \_\_\_\_\_ am / pm***

**The following morning** have a light meal, and begin to take your medications.  
**One hour before you take the Misoprostol**, take the pain reliever prescribed (Tylenol III).

***Insert Misoprostol buccally on: Date: \_\_\_\_\_ at \_\_\_\_\_ am / pm***

Approximately 24 hours after you took the Mifeprex, you should begin the second stage of medication, using the Misoprostol that was provided to you. You will need to place the four (4) tablets of Misoprostol between your cheeks and gums to dissolve. You may swallow normally as they dissolve, but do not swallow the tablets whole, and do not spit them out. You may experience **heavy bleeding and severe, painful, cramping** within hours after the Misoprostol tablets dissolve. You may use full size/maxi sanitary napkins, (NOT TAMPONS). Cramping may get very strong and quite painful. A non-aspirin pain reliever (Tylenol III #6, depending on allergies) will be given to you to help relieve the discomfort. The pain medication is to reduce the discomfort, and may not fully relieve the pain. Take this medication as directed. The bleeding may get quite heavy and the discomfort may get quite severe, but both should gradually subside within a matter of hours.

**YOUR FOLLOW UP APPOINTMENT IS on: \_\_\_\_\_ at \_\_\_\_\_ am / pm**

**Call 954-720-7777 IF YOU EXPERIENCE ANY OF THE FOLLOWING:**

- **Soaking two (2) or more** maxi pads per hour for two (2) consecutive hours.
- **Sustained fever** (temperature greater than 101.0 degrees Fahrenheit) **or onset of fever after inserting Misoprostol.**
- Abdominal pain or discomfort, “feeling sick” including weakness, nausea, vomiting or diarrhea more than 24 hours after using Misoprostol.

**I have received, read and understood the instructions above. I agree to take all medication according to the instructions. I understand I must attend a follow up visit, and I will attend it.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Staff Witness**

\_\_\_\_\_  
**Date**

**Michael J. Benjamin, MD, FACOG**

7777 North University Drive, Suite 102  
Tamarac, FL 33321

Hours: Monday – Friday 8:30am – 5:30pm and Saturdays 8am – 12pm  
Tel: (954) 720-7777 | Fax: (954) 726-2896

**PATIENT DEMOGRAPHICS**

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Number of Previous Live Births:**

Now Living \_\_\_\_\_ Now Deceased \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

**Residence of Patient – County and State:**

\_\_\_\_\_

**Patient Education:**

- 8th Grade
- 9th – 12TH Grade, no diploma
- High school graduate or GED completed
- Some college credit, no degree
- Associate’s degree
- Bachelor’s degree
- Master’s degree
- Doctorate or Professional degree

**Patient Married?**

- Yes
- No

**Patient of Hispanic Origin?**

- No, not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other Spanish/Hispanic/Latina  
(Specify Country): \_\_\_\_\_

**Reason for Pregnancy Termination:**

- Elective abortion
- Abortion performed due to Social or Economic reasons
- Abortion performed due to Emotional/Psychological health of the Mother
- Abortion performed due to Physical Health of Mother that is not life endangering
- Abortion performed due to a Life Endangering Physical Condition
- Abortion performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
- Abortion performed due to Incest
- Abortion to be performed due to Rape
- Fetal Demise

**Patient Race:**

- White
- Black or African American
- Asian Indian
- Guamanian or Chamorro
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- American Indian /Alaska Native
- Native Hawaiian
- Other Asian (Specify)
- Samoan
- Other Pacific Islander (Specify)
- Other (Specify)  
(Specify Country): \_\_\_\_\_

**If there are any questions you were unable to answer, please address them with the counselor.  
Please do not ask at the front window.**