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): _____

_____ 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 ☐Internet

Your Doctor? ☐Dr.'s Name: _____ Other? _____

YOUR PHARMACY :_____**PHONE NUMBER/ 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 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 **<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 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* ☐ *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* ☐ *R/I* ☐ *FD* ☐ *MH* ☐ *FUNERAL ARRANGEMENTS MADE IN ADVANCE BY PT.*

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: _____ Age: _____

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): _____

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 will hold my record to the highest standard of privacy and confidentiality and will only release my personal health 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 its 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** / have court order, and will provide it.

BSSI INFORMED CONSENT TO PREGNANCY TERMINATION WITH IV SEDATION
(Please Initial)

_____ 1. I _____ age _____. Request and consent to the performance upon me of a pregnancy termination procedure, suction, D&C, D&E, by a designated associate physician at BSSI, BSS International, Inc. (hereinafter called "the Center") at 7777 North University Drive, Tamarac, Florida.

_____ 2. I hereby request and authorize BSSI and its designated physicians, to perform upon myself the procedure known as:

□ Elective Termination of Pregnancy or □ Therapeutic Termination of Pregnancy

_____ 3. The purpose of the procedure is to terminate my pregnancy, and I affirm that I have personally chosen pregnancy termination in light of the alternative of continuing with the pregnancy to term. No member of the staff and no one else has coerced or compelled me to terminate the pregnancy at the Center.

_____ 4. I further consent to the taking of cultures and the performance of reasonably indicated tests and procedures in addition to pregnancy termination/surgical treatment of fetal demise, whether or not relating to presently known conditions, if my medical attendants find this necessary or advisable in the course of evaluation of treatment, for management of complications or otherwise.

_____ 5. I hereby acknowledge that I have read and fully understand an attached sheet entitled "Important Information Which Every Patient Should Know Concerning the Termination of Pregnancy Procedure" or "Important Information Every Patient Should Know Concerning the Termination of Pregnancy/Surgical Treatment of Fetal Demise Procedure(s)." I fully understand and accept the various risks set forth therein, and I have had an opportunity to discuss these risks and all other questions which I may have concerning the pregnancy termination/surgical treatment of fetal demise procedure(s) with a medical doctor. My signature at the end of the information sheet indicates my approval and acceptance of all risks set forth therein.

_____ 6. I understand the nature of the pregnancy termination, the procedure to be performed, and alternatives to this procedure including continuing the pregnancy to term, and/or adoption alternatives. The Center is hereby advising me of the availability of the services of social agencies should I desire to continue the pregnancy to term.

_____ 7. I hereby expressly waive any claim or demand which I, or my representatives, may have of any nature, kind or description against BSSI, its agents or employees who participate in the herein stated procedure. I specifically assume any and all responsibility for the above stated procedure, acknowledging that the same is done at my request for my benefit.

_____ 8. I understand the risks and possible complications of having the pregnancy terminated, including but not limited to, infection, blood clots in the uterus, failed or incomplete abortion (tissue left inside the uterus), perforation (puncture in the uterus, cervix, intestines, bladder), reaction to medications including anesthesia, depression, emotional distress, cervical laceration, amenorrhea (no period, uterine adhesions, bleeding problems, heart and breathing problems, ectopic pregnancy, and any other unforeseeable complications (including increased risks from pre-existing conditions), and very rarely death.

_____ 9. I understand the emotional distress is a potential complication of this procedure. Individual women cope differently with abortion. Most women go through the process with minimal emotional effects, but in some cases, professional help may be required. I understand that I can return to the Center if I need additional counseling and/or referral if this should occur.

_____ 10. I have fully and completely disclosed my medical history, including allergies, blood conditions, heart and/or breathing problems, prior medications or drugs taken and reactions I have had to anesthetics, medicine or drugs. I consent to my physician's reliance on this disclosure as full, accurate and complete.

_____ 11. I consent to the administration of such anesthesia as may be deemed necessary or advisable by my physician or associates.

_____ 12. I understand that a pregnancy termination/surgical treatment of fetal demise procedure requires the removal of the products of conception and other tissue, and I consent to disposal or use of these products and tissue by the physician in any manner they deem appropriate. If I have questions or complications after leaving, I agree to call the physician immediately. I have been provided contact information for the physician. I agree that if I should seek treatment for complications resulting from the termination/surgical treatment of fetal demise procedure from any other physician prior to consulting with the physician, the physician will not be able to assist me further. I understand and agree that the physician is under no obligation to provide me with treatment or hospitalization for complications that arise from the pregnancy termination procedure.

_____ 13. I understand the nature of the post operative recovery period. I understand the list of instructions along with the medications, which I must take. I understand and realize the importance of a follow up appointment and understand it is my responsibility to come to this appointment. I understand I should contact the Center *first* if I have any questions or concerns about my recovery.

_____ 14. I understand that in very rare circumstances, the Center may deem in my best welfare to transfer me to the hospital. I understand in this rare occurrence, I will be held responsible for all bills accrued. I further understand the Center cannot be held for a breach in confidentiality. In emergencies, it is sometimes necessary to contact other individuals.

_____ 15. I understand that I have been advised by the Center to remain in the area of care for two weeks following the termination. I understand if I choose to go against the advice, that I take full responsibility for my care, I agree not to hold the Center, its physicians or any staff liable for any harm or injury that may result from my leaving the area.

I understand this informed consent and the information statement with which I have also been furnished are legal documents and is my desire and agreement that all other parts continue in force, and are binding upon me. These legal documents reflect my wishes, and if any part of these documents is held to be invalid, it is my desire and agreement that all other parts continue in force. I certify that I have thoroughly read and fully understand the above informed consent, and that I agree in light of that consent and the information concerning pregnancy termination procedures which have been furnished to me, the pregnancy termination procedure I have requested.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF WITNESS DATE

BSSI

IMPORTANT INFORMATION EVERY PATIENT SHOULD KNOW CONCERNING TERMINATION OF PREGNANCY / SURGICAL TREATMENT OF FETAL DEMISE PROCEDURE

1. SURGICAL PROCEDURE: A termination of pregnancy/induction evacuation of fetal demise procedure of any kind is a surgical procedure which, like all surgical procedures of both minor and major importance, involves certain risks to the patient. These risks are outlined below.

2. PROPER INFORMATION: The physician who performs a pregnancy termination/induction evacuation procedure must be provided with complete information by the patient in order to correctly evaluate her medical needs and her physical condition. In addition, the physician must be provided with the results of laboratory tests in order to better prepare him/her for performing the procedure. Failure to provide the treating physician with adequate and accurate information may lead to unnecessary complications. Every patient considering any surgical procedure should provide her physician with a complete medical history, including allergies, blood conditions, prior medications, or drugs taken, adverse reaction to anesthetics, medicines or drugs. Patients should also permit their physicians to take any and all other tests which the physician deems advisable for the evaluation or treatment of her care. Of particular importance for pregnancy termination cases is a complete and accurate history of menstruation for the six months prior to the termination procedure.

3. ANESTHESIA: Anesthesia is used in most surgical procedures to eliminate or reduce the pain from the performance of the surgical procedure. Anesthesia is not foolproof, and in some cases, the patient will experience pain and discomfort even though anesthesia is administered. In termination of pregnancy/induction evacuation procedures, a local anesthetic will be used along with your choice of an intravenous anesthesia. Anesthesia may result in temporary mental impairment.

- A local anesthetic does not always eliminate pain. In some cases, local anesthetics cause severe reactions, even shock. No guarantee can be given that the use of a local anesthetic will make the pregnancy termination procedure painless or that unfavorable or even severe reactions will not result.
- Conscious sedation may render the patient in a sleep-like state. The patient will become very groggy and in some instances experience nausea. Medications administered are intravenous sedatives and anesthesia agents. Medications may minimize pain, or may not eliminate pain completely each person reacts differently to intravenous sedatives and anesthesia agents.

4. MANADATORY REQUIREMENT: I understand that I will be administered anesthesia as part of my surgical procedure. I agree not to drive a vehicle or leave the facility without a licensed driver to assist/drive me home. **I understand that if I violate this requirement, it could result in serious injury or death to myself and to others.** Therefore, if I cannot get a ride from a licensed driver, I will so advise Dr. Michael Benjamin or any of his agents who will assist me in making alternative transportation arrangements at my cost. I hereby acknowledge

5. COMPLICATIONS IN GENERAL: The complications associated with pregnancy termination/induction evacuation procedures are generally considered to not be more severe than those associated with childbirth and may be generally less severe than those associated with childbirth. Nevertheless, as with all surgical procedures, there are inherent risks of minor and major complications, including death which may occur without the fault of the physician. No guarantee can be given that complications will not result. With respect to pregnancy termination/induction evacuation procedures, there is a possibility of perforation of the uterus and resulting injuries that could require that a hysterectomy be performed. In some cases, all of the tissue cannot be removed and in such cases, fever, bleeding and infection may occur. Adverse reactions to medicines and anesthesia can also occur and these reactions include pain, cramps, and even convulsions. In rare cases, the contents of the uterus may not be entirely removed and you could continue to be pregnant. The importance of a follow-up exam cannot be stressed enough in order to avoid and care for possible complications. Generally, contraceptives are administered or used after the pregnancy termination /induction evacuation procedure and these contraceptives can themselves result in adverse complications.

6. FOLLOW-UP EXAMINATION: In order to minimize the risk of complications from the pregnancy termination/induction/evacuation procedure and to limit the severity of side effects which may occur, a follow-up examination is always necessary. I understand it is my responsibility to seek follow-up care and have been advised to return to BSSI and its designated physicians, other physician of my choice, or other healthcare facility within 2-3 weeks post operatively.

7. PATIENT'S RESPONSIBILITIES: The standard of medical practice of any physician is to be judged in accordance with those standards reasonably acceptable to other physicians practicing in similar facilities within the United States. This means that the Physician attending the patient at the Center, while fully qualified to perform the procedure, cannot be expected to have unusual or extraordinary talents, but can be expected to be of the same caliber as other physicians who perform procedures in the medical community.

8. CENTER'S RESPONSIBILITY: The center will attempt to maintain a reasonable level of financial responsibility; however, there can be no assurance that the center will maintain or will be able to maintain insurance coverage sufficient to satisfy all claims.

The undersigned patient acknowledges that she read the foregoing information regarding the termination of pregnancy/induction evacuation procedure and certifies that she fully understands and accepts the risks set forth above.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF WITNESS DATE

BSSI
PROBLEMS THAT MAY OCCUR

I understand the risks and possible complications of terminating this pregnancy. I understand that some of these problems may be avoided or lessened if I follow the postoperative instructions and care.

Common Risks and Complications

Abortion is one of the safest medical procedures performed in the United States. In order to provide you with adequate informed consent, you need to understand the risks and complications.

1. Retained tissue: A small amount of tissue can be left inside the uterus. If this should occur, you should return to this facility. It is also important that you return for your 2-week follow-up appointment.

2. Failed abortion: The procedure will be repeated at the facility at no extra charge. It is important that you return for your follow-up appointment.

3. Infection: Infection is very rare, especially if you follow our post-operative care instructions. You need to call the office if you have a fever over 101.0

4. Ectopic pregnancy: This is a pregnancy that is outside the uterus, usually in the fallopian tube. It is not a complication of abortion, but is something that may occur naturally. If the doctor suspects this, you will be given instructions on what to do next.

5. Heavy bleeding: Very rarely women may experience heavy bleeding after a termination. Again, this can be avoided or minimized by following instructions. You should call if you bleed through a pad in more than one hour.

6. Reaction to medications: This may happen with any surgery. We have other medications that can help if this occurs. It is important that you provide us a complete and accurate medical history.

Very Rare Complications

Below is a list of **very rare** complications. Please feel free to ask questions if you need further explanation.

Cardiac arrest
Respiratory depression/arrest
Hemorrhage
Uterine perforation
Injury to cervix and/or uterus
Injury to intestines or bladder
Pelvic infection and/or surrounding tissue, organs
Laparoscopy
Reaction to anesthesia
Blood clots in uterus
Ovarian pain
Septicemia: blood infection
Thrombophlebitis: blood clots in veins
Absence of menstrual periods
Blood transfusion
Hospitalization
Hysterectomy
Aggravation of pre-existing conditions
Any unforeseeable complications
Death (Very rare)

_____ _____

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 – 5:00pm and Saturdays 8am – 12pm
Ph: (954) 720-7777|Fax: (954) 726-2896
After Hours, for **Emergencies only**, call: 954-790-7770

Laminaria & Pre-Operative Instructions

Today you have had one or more laminaria (dilators) placed in the natural opening to the uterus. This will dilate and soften your cervix, making the procedure as safe as possible. If you are having a three day procedure, then this placement of laminaria will occur tomorrow as well.

Cotton gauze sponges have been placed in the vagina, like a tampon, and may have been coated in betadine (an antiseptic) which will cause them to have a brownish color. It is important that you do not pull on the sponges. If the begin to fall out from the vagina, gently push them back inside. If the sponges fall out, do not be alarmed, put them in a plastic bag and bring them with you to your appointment tomorrow. **IF THE LAMINARIA FALLS OUT, CALL OUR OFFICE IMMEDIATELY. IF IT IS AFTER HOURS, CALL OUR EMERGENCY LINE.**

As your cervix dilates, you may experience cramping. These cramps may be mild, or may become more intense. Many factors will influence the level of discomfort that you feel. You may take the prescription pain medication to relieve the discomfort. It is normal to experience some nausea and even vomiting. Most patients do not complain of this symptom, but do not be alarmed if it happens to you. **IF THE PAIN INTENSIFIES, AND YOU BEGIN TO HAVE CONTRACTIONS, CALL US RIGHT AWAY. IF AFTER HOURS CALL OUR EMERGENCY LINE.**

You may shower as normal, but do not take a tub bath, or insert anything into the vagina after the laminaria appointment. Under no circumstances should you remove the laminaria. Once it is inserted, that is the start of the procedure and you **CANNOT CHANGE YOUR MIND.**

You may experience some spotting tonight. It is possible to have a watery discharge. Both are normal. **IF YOU HAVE VAGINAL BLEEDING HEAVIER THAN A NORMAL PERIOD, OR ABUNDANT WATERY DISCHARGE, CONTACT US IMMEDIATELY AT OUR EMERGENCY NUMBER.**

IT IS VERY IMPORTANT YOU HAVE NOTHING TO EAT OR DRINK FOR 8 HOURS PRIOR TO YOUR PROCEDURE. However, if you are experiencing discomfort, or if you are taking prescribed medication, and have been told by our office you can continue to take it until your procedure, then do so with a small sip of water only. If you are diabetic, or if you are taking additional prescription medication, make sure you have been instructed on how and when to take your medications between now and your procedure.

As you will receive anesthesia and be too sleepy to drive upon discharge, you will not be able to drive after surgery. You are required to have a **KNOWN COMPANION PROVIDE YOU WITH SAFE, RELIABLE TRANSPORTATION TO AND FROM OUR OFFICE.** Please allow approximately 3-4 hours at our office. Advise your companion to pick you up on the north side of the building where the orange parking cones are. They may call our office to notify us of their arrival.

You have been given an antibiotic, or a prescription for one, to start taking today. Take the medication as prescribed until completely gone. It is NOT necessary to take the medication within the eight hours of fasting.

Laminaria Day 2 (if Needed Only) Appointment Date: _____ Time: _____

Surgery Date: _____ Time: _____

Remember do not eat or drink for 8 hours before Surgery Appointment

INFORMATION AND CONSENT TO SECOND TRIMESTER

TWO AND THREE STAGE

TERMINATION OF PREGNANCY/SURGICAL TREATMENT OF FETAL DEMISE

During early pregnancy (if not advanced beyond the 12th-15th week), abortion can usually be accomplished through the use of surgical instruments alone, as a one day procedure.

After that, for the second trimester, a **two-stage** procedure is frequently used. For this procedure, the patient is seen two times. The first day consists of dilating the cervix. The physician inserts into her cervix a small solid device called an osmotic dilator. It is made of a synthetic material and is about the size of a matchstick when inserted. One or more osmotic dilators may be used as necessary to dilate the cervix. Insertion generally takes 5-10 minutes with minimal discomfort. Prior to the osmotic dilator insertion, the patient is given appropriate instructions and once the osmotic dilator has been inserted she is allowed to leave the office.

During the interim period, the osmotic dilator absorbs moisture from the body and gradually expands to about three times its original size. In doing so it slowly and gently dilates and softens the cervix. Twelve to twenty-four (12-24) hours later, when the patient returns for her final visit, the patient will receive a dosage of Cytotec (Misoprostol) to assist in the dilation. After that, the physician removes the osmotic dilators inserted the previous day, and the termination is completed by emptying the uterus.

At the end of the second trimester, at 24 weeks, a **three-stage** procedure is more usually done, which requires two consecutive days of laminaria insertion with Digoxin used as the medication. The patient must then come in for a third visit, in which the termination is completed, on the final day, the patient will receive the dosage of Cytotec (Misoprostol) to assist in the dilation, after which the termination is completed by emptying the uterus.

A slightly greater risk is involved in the termination of pregnancy over twelve (12) weeks than in earlier abortion. However, the use of the two or three stage procedure may decrease the difference considerably. In the later pregnancy, the risk of infection or incomplete abortion is said to be greater. Also, there is somewhat more immediate blood loss, but not so much as to be a threat to the health of the woman. This procedure has less risk than delivery at term.

Osmotic dilator insertion is ordinarily a simple and quick procedure. Very infrequently, however, certain complications may arise. These complications may include infection, perforation of the cervix, spontaneous abortion and/or septic abortion. With the osmotic dilator in place, the patient may experience side effects including some cramping, bleeding, and/or watery discharge. Symptoms including contractions, expelling of laminaria, and/or ruptured membranes require immediate treatment. It is your responsibility to call the office or the after-hours emergency line immediately.

Once the osmotic dilator is inserted, it is mandatory that the patient returns to the facility for the second stage of the procedure within a 24-hour period from the previous day. Failure to return on time may result in complications such as infection, miscarriage, toxic shock syndrome or death. If the osmotic dilator is removed, but the second stage of the procedure is not complete, there is an increased risk of spontaneous abortion.

_____ **Any complication resulting from failure to return within 24 hours each day is my responsibility and not that of the doctor involved. I will be responsible for any medical costs or physical damages I incur as a result of my actions. I hereby release Dr. Michael Benjamin and staff for any harmful consequences, which may result from these actions.**

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

CONSENT FOR INSERTION OF OSMOTIC DILATORS (STAGE ONE)

I, _____, have been informed that laminaria will be used to facilitate the dilation of my cervix as the first and/or second stage in terminating my current pregnancy. I have been provided an antibiotic, with instructions, as a precautionary measure as well as pain medication for comfort. I understand that I must return at the time scheduled and that the laminaria must be removed within twenty-four (24) hours of insertion due to risk of infection. I am also aware that once inserted, there is substantial risk to myself and my current fetus should I decide NOT TO PROCEED with termination of my current pregnancy. I affirm that all aspects of this procedure including risks have been fully explained to me and that all of my questions have been answered to my complete satisfaction. By signing below, I state that I fully understand of the information that has been provided to me both verbally and written in regard to this procedure. If I fail to return to the provider(s)/facility above as scheduled or if I choose not to terminate my current pregnancy after insertion of laminaria, I release all parties noted above form any and all liability resulting from my decisions and/or actions. I hereby request and consent to proceed with insertion of laminaria to terminate my current pregnancy.

I will **NOT** be traveling farther than **45 minutes** away from the clinic and I will be staying at: ☐ _____

☐ **I need a hotel**

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Three Day Procedures Only

CONSENT FOR INSERTION OF OSMOTIC DILATORS (STAGE TWO)

I, _____, have been informed that laminaria will be used to facilitate the dilation of my cervix as the first and/or second stage in terminating my current pregnancy. I have been provided an antibiotic, with instructions, as a precautionary measure as well as pain medication for comfort. I understand that I must return at the time scheduled and that the laminaria must be removed within twenty-four (24) hours of insertion due to risk of infection. I am also aware that once inserted, there is substantial risk to myself and my current fetus should I decide NOT TO PROCEED with termination of my current pregnancy. I affirm that all aspects of this procedure including risks have been fully explained to me and that all of my questions have been answered to my complete satisfaction. By signing below, I state that I fully understand of the information that has been provided to me both verbally and written in regard to this procedure. If I fail to return to the provider(s)/facility above as scheduled or if I choose not to terminate my current pregnancy after insertion of laminaria, I release all parties noted above form any and all liability resulting from my decisions and/or actions. I hereby request and consent to proceed with insertion of laminaria to terminate my current pregnancy.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

CONSENT TO PERFORM AMNIOCENTISIS WITH INJECTION OF DIGOXIN: PREGNANCY TERMINATION

I, _____, provide authorization and consent to Michael Benjamin MD, or another physician designated by him, to perform an amniocentesis with injection of Digoxin. It has been explained to me that the purpose of this procedure is to stop the fetal heart and surgically terminate my current pregnancy as planned. It has also been explained to me that with any surgical procedure but not limited to infection, hemorrhage, and damage to surrounding organs or death.

Any complication of this procedure may result in the need for emergency transport to an area hospital and need for immediate surgical intervention other than the surgery currently planned. I provide my authorization and consent to any transport and treatment deemed necessary for my well-being as determined by Michael Benjamin MD, or another physician as recommended.

I confirm that I have read this consent and had all of my questions answered to my full understanding and complete satisfaction, and request and consent to proceed with the procedure above and release Michael Benjamin MD, or any agent acting on his behalf from any and all liability.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Michael J. Benjamin, M.D.
7777 N. University Drive, Suite 102
Tamarac, FL 33321
(954) 720-7777

Cytotec (Misoprostil) Consent

Please place your initials on each line below

_____ I understand the purpose of Cytotec is to soften and dilate my cervix for the purpose of facilitating the completion of the termination of pregnancy by surgical abortion.

_____ I understand that a medicine called Cytotec (Misoprostil) will be used to assist in the process of softening and opening my cervix. Although this medicine is widely used by abortion clinics worldwide, it is NOT approved for this purpose by the U.S. government. It is approved for treating stomach ulcers, and has been well studied. This type of "off label use" is legal and widely accepted for various medications.

_____ I understand that Cytotec may cause the following side effects:

- Cramping
- Vaginal Bleeding
- Diarrhea
- Headache
- Fever

_____ I understand that once the Cytotec is administered, the abortion procedure must be completed and failure to do so could cause birth defects.

_____ I understand that Cytotec is not always 100% effective and it may be necessary to have Osmotic Cervical Dilators (Laminaria or Dilapan) inserted. The dilators remain in place overnight and the procedure will be completed the following day.

_____ I understand and consent to treatment by use of Cytotec.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Authorization for the Release of Fetal Tissue

(Do not sign if you are using a Funeral Home)

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

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Request to Release Specimen for Genetic Testing

This requires that your OB-GYN provide a Completed Lab Requisition IN ADVANCE

_____ I have chosen to have a genetic study performed on this pregnancy. I have provided a completed lab form from my physician for this purpose. I release Dr. Benjamin, M.D., and any staff from any liability in the handling and/or results that may be attained or the viability of the specimen to provide a result.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Michael J. Benjamin, MD, FACOG
7777 North University Drive, Suite 102
Tamarac, FL 33321
Hours: Monday – Friday 8:30am – 5:00pm and Saturdays 8am – 12pm
Tel: (954) 720-7777|Fax: (954) 726-2896

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

Post-Operative Instructions

1. Eat lightly and drink plenty of clear fluids. Fluid intake is important to your recovery.
2. After your surgery, it is important to go home and rest for the duration of the day. No heavy lifting, long walks, or straining.
3. Avoid driving, operating machinery or making important personal or business decisions until the following day.
4. **FIRST TRIMESTER PATIENTS:** Nothing introduced into the vagina for 48 hours. Bathing as usual.
   SECOND TRIMESTER PATIENTS: Do not insert anything into the vagina for two weeks. Bathing as usual.
5. You will have medications prescribed which will be sent electronically to your pharmacy., it is important that you fill these prescriptions and that you **TAKE ALL MEDICATIONS AS DIRECTED.**
6. Cramping is normal and may vary from minimal to severe. One of the prescriptions provided is a pain medication. Take it as directed to relieve the discomfort. There will be antibiotics prescribed, please start them today and take until they are finished.
7. You may encounter bleeding in the next few weeks. The bleeding may come and go irregularly, and some patients may have no bleeding at all. This is normal.
8. Call the number above for any of the following:
   - Fever greater than 101 degrees Fahrenheit that persists for more than one hour.
   - Soaking a full size MAXI pad within one hour and/or passing quarter size blood clots or larger.
   - Pain greater than experienced with a severe menstrual period.
   - If you call us, please have **the date of your procedure, your pharmacy phone number, and the number of MAXI pads you have used in the last four (4) hours.**
9. Your first period usually returns in 6 to 12 weeks following surgery if you do not begin on birth control. The bleeding may be heavier, last longer and cramps may be stronger than your usual period. If you began oral contraceptive pills, patch, or vaginal ring, you can expect a period within the last 2 weeks of the contraceptive cycle. Your first period may be much heavier, last longer and be more crampy or painful than usual. Understand that it takes 2 to 4 cycles on birth control before your period becomes regular. You can **begin oral contraceptives on the Sunday following the abortion.**
10. Your breast(s) may become engorged (i.e. sore, tender, fluid filled) and leak within days after surgery: This is NORMAL. There is no medication available to treat breast engorgement. Wear a good support bra 24 hours a day, do not stimulate (squeeze) the breasts. The discomfort may increase slightly before resolving. Take your pain medication and gently apply cool compresses to the breasts as needed for the discomfort.
11. **It is your responsibility to return to this office or your private physician for a post-operative examination if you would like to have one.** The optional postoperative appointment timeframe for your procedure is 2(two)-3(three) weeks. There is no charge to patients for the routine post operative exam if you present **within 28 days** from the date of your surgery. Any non-surgical related examinations or tests not related to the abortion, will be your financial responsibility.

No prescription refills or replacements will be provided after this visit. If you wish to continue your gynecological care with us, please call to schedule your appointment at least two weeks in advance. If you have received surgical and post-operative care only, you **will be a NEW GYNECOLOGY PATIENT**

Especially for: _____

YOUR POST-OP APPOINTMENT: Please call our office to set up your post-op appointment

OR: _____

Comments/Instructions: _____

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PATIENT DEMOGRAPHICS

Patient Name: _____ **Age:** _____ **Date:** _____

Number of Previous Live Births:
Now Living _____ Now Deceased _____ Miscarriages _____ Abortions _____

Residence of Patient – County and State:
_____

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): _____

Patient Race:
○ White
○ Asian Indian
○ Chinese
○ Japanese
○ Vietnamese
○ Native Hawaiian
○ Samoan
○ Other (Specify)
○ Black or African American
○ Guamanian or Chamorro
○ Filipino
○ Korean
○ American Indian /Alaska Native
○ Other Asian (Specify)
○ Other Pacific Islander (Specify)
(Specify Country): _____

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

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

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