CENTER FOR WOMEN'S HEALTH
CONSENT FOR ABORTION PROCEDURE

Please Initial

_____ **1**. I, _____, **AGE:** _____, hereby consent to the performance upon me of an abortion procedure that will be that of a dilatation and suction curettage "D&C" or a dilatation and evacuation "D&E" using LOCAL ANESTHESIA *(paracervical block)* and/or if clinically indicated, INTRAVENOUS SEDATION AND ANALGESIA *(conscious sedation)* by Traci L. Nauser, MD or Tristan R.P. Fowler, DO.

_____ 2. The doctor will perform the abortion procedure by numbing the cervix with injections of a local anesthetic. After waiting for the medication to take effect, the doctor will dilate the cervical opening to the uterus using sterile rods. In some cases, further cervical preparation will be done using medication (Misoprostol) and/or Laminaria (cervical dilators). Tubing attached to a suction machine will then be used to remove the pregnancy tissue from the uterine cavity. Special forceps will also be used in the "D&E" procedure to remove fetal tissue. A metal instrument called a curette may also be used to gently scrape the uterine walls. The actual procedure typically takes between 30 seconds to 15-20 minutes, depending on the number of weeks of the pregnancy.

_____ 3. I understand that my options regarding this pregnancy are: (1) waiting and thinking more about my decision, (2) continuing the pregnancy and becoming a parent, (3) continuing the pregnancy and planning for an adoption, (4) ending the pregnancy with an abortion. I choose to have an abortion to end this pregnancy.

_____ 4. I acknowledge that I am acting on my own behalf, and that my decision to have an abortion is voluntary.

_____ 5. I further consent to the performance of any additional emergency procedures, which may be indicated because of unforeseen conditions arising during, or after the abortion procedure.

_____ 6. I have disclosed my complete medical history to the doctor; especially with regard to any allergies or adverse reactions to medications or anesthetics; any previous surgical procedures or pregnancy terminations; as well as telling them of any medications or herbal supplements that I have taken since my last menstrual period.

_____ 7. My Last Menstrual Period (L.M.P.) began on: ____/____/_____ and: it WAS / WAS NOT normal *(circle one).*

_____ 8. I understand that the health risks of an abortion are much less than those of other surgical procedures, and far less than those associated with a full-term pregnancy and delivery (vaginal or cesarean). Any surgical procedure involves the risk of possible complications (up to death) that could occur without any fault of the doctor.

_____ 9. Some of the rare possible complications of an abortion include but are not limited to:

- **a.** Retained blood clots and/or tissue requiring re-suction, or "D&C."
- **b.** "Missing" and early intrauterine pregnancy or an Ectopic (tubal) pregnancy
- **c.** Allergic reaction
- **d.** Cervical laceration requiring stitches
- **e.** Hemorrhage (excessive bleeding)
- **f.** Infection
- **g.** Formation of scar tissue
- **h.** Failure of the blood-clotting mechanism (Disseminated Intravascular Coagulopathy) with need for blood transfusion
- **i.** Uterine perforation with damage to other organs (blood vessels, bladder, intestines), Hospitalization, Major Surgery, Hysterectomy, Sterility.
- **j.** Placenta Accreta (Abnormal placental implantation) due to previous Cesarean Section, with possible excessive bleeding or uterine perforation
- **k.** Death

_____ 10. I realize that such complications can be caused by my own medical condition(s) or my actions; by the treatment of alternative follow-up physicians; or may occur spontaneously, WITHOUT the fault of Dr. Nauser or Dr. Fowler.

_____ 11. If there are any problems after surgery, I agree to PROMPTLY notify the doctor as explained in the *Aftercare Instructions*. I understand that failure to promptly notify the doctors may lead to delay of proper treatment, and could cause further complications. I understand that if I chose to seek alternate treatment elsewhere, I may NOT hold Dr. Nauser or Dr. Fowler responsible for subsequent medical expenses, or any loss experienced as a result thereof.

_____ 12. I agree to undergo a post-operative exam in 2-3 weeks. Failure to do so shall absolve Dr. Nauser or Dr. Fowler of ALL medical, legal, or financial responsibility for any surgery-related problems that might arise at a later date.

_____ 13. I authorize the disposal of any tissue removed, in accordance with applicable state law.

_____ 14. I consent to the exchange of medical records between The Center for Women's Health and any other provider, physician, hospital, or clinic pertaining to my medical treatment.

_____ 15. I agree NOT to drive or make important decisions for 24 hours, if I have received intravenous sedation.

_____ 16. I acknowledge that it is MY responsibility to ask the doctor ANY questions that I have pertaining to the abortion procedure or to this consent form, BEFORE I sign this form below.

_____ 17. I am not seeking to have an abortion solely on account of the sex of the fetus.

I CERTIFY THAT I HAVE READ, INITIALED, AND FULLY UNDERSTAND THIS CONSENT FORM

Patient's name: _____

Patient's signature: _____ Date: _____

This patient, named above, has received an explanation of the nature, purpose, alternatives to, and risks of the proposed procedure. I have offered to answer any questions and have fully answered any questions from the patient. I believe that this patient fully understands the procedure, and its possible consequences, and has made a fully informed decision to consent to the procedure.

Physician signature: _____ **Date:** _____

Center For Women's Health
4840 College Blvd
Overland Park, Kansas 66211

Patient Name:_____**HIPAA CONSENT** **Chart Number:**_____

In accordance with patient confidentiality and privacy laws, we will need your written permission to discuss appointments, test results, medical records, prescriptions and your account information with anyone other than yourself. Please ***LIST BELOW ANYONE*** you give permission to access your information (**including billing/account balance information**) by phone, fax or mail.

- ○ No one (I understand this includes spouse/doctors/etc)
- ○ Spouse/Children_____
- ○ Other_____

I understand that I have the right to revoke this authority at anytime, but I must do so in writing. The revocation does not apply to any information already released.

_____ _____ _____
Signature of Patient or Legal Guardian/Parent Relationship Date

I hereby acknowledge that I have been offered a copy of Center for Women's Health **Notice of Privacy Practice.**

Initial_____ **Date**_____

CONSENT TO CORRESPOND ELECTRONICALLY

While Center for Women's Health takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge if I use electronic mail to initiate contact with Center for Women's Health regarding my medical care, the physician and/or his representatives have my permission to correspond via that email address.

I give permission for Center for Women's Health physician and/or staff members to email me at _____@_____ regarding my medical care.

AUTHORIZATION FOR TREATMENT

I hereby authorize medical treatment for myself or my dependent as deemed necessary by the providers of Center for Women's Health.

PHARMACY BENEFIT MANAGEMENT CONSENT

In order to ensure we have the most accurate and up-to-date information on your medication, we are able to import all of your current medications directly from your pharmacy(s) into our Electronic Health Records via a SECURE connection. We will continue to verify your medications, but importing them electronically saves you and our staff time. By providing us with your signature below, you are authorizing us to import your medications on your behalf. I hereby authorize Center for Women's Health to import my medications from my pharmacy(s) into their electronic health record.

By signing this consent form you are agreeing that Center for Women's Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

AUTHORIZATION/ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private, HMO/PPO, and commercial insurances as well as third party payors be made on my behalf to Center for Women's Health for any services furnished to me or my family by Center for Women's Health. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment or for determination of benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. In addition.

_____ _____ _____ _____
Signature of Patient or Legal Guardian/Parent Relationship Date Center for Women's Health Representative Signature (verified)

Center For Women's Health
4840 College Blvd
Overland Park, Kansas 66211

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. Any balances, co-pay and/or deductibles are due prior to seeing the physician. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. You also understand you are responsible for any amount not covered by your insurance. In the event your insurance company requests a refund of the payment made, you will be responsible for the entire charge amount. Our office makes no guarantee of benefits. **Any quoted benefits provided by your insurance company are considered general overview and only a guideline until payment is received. All services are subject to review by the insurance company once a claim is received and they determine if a payment will be made.**
A parent who brings a minor child to our office for medical care is legally responsible for payment of all charges.

If you do not have insurance, payment is expected when services are rendered. If payment in full is not possible at the time services are rendered, payment arrangements may be made in advance. You must notify the office prior to your appointment if you are unable to pay in full.

I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, interest, and attorney fees.

I understand if I am unable to make a scheduled appointment I must cancel within 24 hours of my appointment time. I understand if appointments are repeatedly missed, Center for Women's Health may be forced to dismiss me from the practice.

Center for Women's Health accepts payments in the form of Credit Card (Discover, Visa and MasterCard) or cash. We do not accept checks.

CREDIT CARD ON FILE POLICY

At Center for Women's Health, we require keeping your credit or debit card on file as a method of payment for the portion of services your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. **I understand it is my responsibility to always keep an active credit or debit card on file in order to stay compliant with the financial policy. Failure to do so, may result in dismissal from the practice.**

I authorize Center for Women's Health to charge the portion of my bill that is my financial responsibility to the following credit or debit card:
☐ Visa ☐ Mastercard ☐ Discover
Credit Card Number _____
Expiration Date _____ / _____ / _____
Cardholder Name _____
Signature _____
Billing Address _____
City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Center for Women's Health to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me or my dependents by Center for Women's Health. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give notification to Center for Women's Health in writing and the account must be in good standing.

Patient Name (Print): _____
Patient Signature: _____
Date: _____ / _____ / _____

I have read the above information. I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT.

_____	_____	_____	_____
Signature of Patient or Legal Guardian/Parent	Relationship	Date	Center for Women's Health Representative Signature (verified)