CENTER for WOMEN'S HEALTH
CONSENT for "MEDICAL ABORTION"

1. _____ I have read the **Medication Guide** for using *Mifeprex* to end my pregnancy.
2. _____ I have discussed the medical abortion with Dr. Nauser at Center for Women's Health.
3. _____ Dr. Nauser answered all my questions and told me about the risks and benefits of using Mifeprex to end my pregnancy.
4. _____ I believe I am no more than **9 weeks 6 days** pregnant.
5. _____ I understand that I will take *Mifeprex* at the office of Dr. Nauser on **Day 1**
6. _____ I understand that I will take *misoprostol* sublingually (under my tongue) 2 (two) days later: **Day 3**.
7. _____ Dr. Nauser gave me advice on what to do if I develop heavy bleeding or need emergency care due to the treatment. Call the office: (913) 491-6878), 24 hours a day, and do **not** go to the emergency room unless advised by Dr. Nauser.
8. _____ Bleeding and cramping do not necessarily mean that the pregnancy has ended. **I agree to return to this office in 2 weeks (Day 14)** after I take both medications to be sure that the pregnancy has ended, and that I am well.
9. _____ I know in some cases (2-7 per 100) the treatment does not work, and I hereby agree – **before I start** – that I will have an in-office abortion if the medication fails to end the pregnancy.
10. _____ I understand that if this pregnancy continues after **any** part of the treatment, there is a chance that there will be birth defects. If the pregnancy continues after treatment with *Mifeprex* and *misoprostol*, **I hereby agree to end the pregnancy**, possibly including a surgical procedure (D&C) at **no additional** charge.
11. _____ I understand that if the medicine I take does not end the pregnancy, and I decide to have a surgical procedure to complete the process, or if I need a surgical procedure to stop bleeding, Dr. Nauser will do the procedure at **no** additional cost. This must be done at their office.
12. _____ I have the name, address and phone number, (913) 491-6878, for Dr. Nauser, and know that I can call **24 hours a day** if I have any questions or concerns.
13. _____ I choose to take *Mifeprex* to end my pregnancy and will follow the advice of Dr. Nauser about when to take each drug and what to do in an emergency.
14. _____ **I hereby agree to do the following**:

- Contact Dr. Nauser (913) 491-6878 right away if I have a fever of **100.4° F** or higher, that lasts for more than **4 hours**, or severe abdominal pain.
- Contact Dr. Nauser (913) 491-6878 right away if I have heavy bleeding (soaking through 2 [two] thick full-size sanitary pads per hour for 2 [two] consecutive hours).
- Contact Dr. Nauser (913) 491-6878 right away if I have severe abdominal pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting or diarrhea, for more than **24 hours** after taking *misoprostol.*
- Take the **MEDICATION GUIDE** with me if I am told to visit an emergency room or a physician who did not give me the medication, so that they will understand that I have taken *Mifeprex*.
- Return to the Center for Women's Health **14 days** after beginning treatment to be sure that my pregnancy has ended and that I am well.

Patient Signature: _____ Patient ID Number: _____

Patient Name (print): _____ Date: _____ / _____ / _____

Physician's Signature: _____

Physician's Name: _____ Date: _____ / _____ / _____

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.

_____ 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

_____ 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 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 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:** _____

WHAT TO EXPECT WITH A *MEDICAL ABORTION*

A Safe and Effective Option:

Mifeprex is the only FDA-approved non-surgical option for ending early pregnancy. More than 2 million women in the United States have used *Mifeprex* since it was approved by the FDA in September 2000. Mifeprex is 92-95% effective for safely ending pregnancy (2-7% of women will need a surgical procedure to end the pregnancy or stop heavy bleeding).

How *Mifeprex* Works:

Mifeprex is a pill that blocks the hormone, progesterone, which is needed for your pregnancy to continue. *Mifeprex* causes the pregnancy to stop growing. Another medicine, *misoprostol*, causes the body to expel the dead pregnancy. *Mifeprex* is not approved for ending later pregnancies. Early pregnancy means it is 69 days (9.6 weeks), or less since your last menstrual period began. *Mifeprex* is taken orally and allows you to avoid anesthesia or surgery in most cases.

How to Take *Mifeprex*:

Please read the **MEDICATION GUIDE** before taking *Mifeprex.* The regimen for *Mifeprex* requires that a woman make **TWO** visits to our office over a two-week period. (Day 1 and Day 14)

Day 1 At Our Office:

- Read the **Medication Guide**.
- Discuss the benefits and risks of using *Mifeprex* to end your pregnancy.
- If you decide *Mifeprex* is right for you, sign the **Patient Consent**
- After getting a sonogram, swallow **1 tablet** (200mg) of *Mifeprex.*

Day 3 At Your HOME:

- Take **4** *misoprostol* tablets sublingually (under your tongue), and swallow after 20-30 minutes.
- *Misoprostol* may cause cramps, nausea, diarrhea, and other symptoms. Dr. Nauser may send you home with a prescription for these symptoms.

Day 14 At Our Office:

- This follow-up visit is very important. You **must** return to the office 14 days after you have taken *Mifeprex* to be sure you are well and that you are not pregnant.
- We will check whether your pregnancy has completely ended. If it has not ended, there is a chance that there will be birth defects. If you are still pregnant, you have previously agreed to end the pregnancy, and the doctor will talk with you about the other choices you have, including a surgical procedure (D&C) to end your pregnancy.

Support:

Mifeprex offers you a more private option, with support and counseling readily available throughout the process. If you have routine questions, you can call our staff during regular office hours. Use the same number to call in case of an emergency. You should keep your **Medication Guide** with you if you are told by us to go to an emergency room or a physician other than Dr. Nauser, so they know you are undergoing a medical abortion with *Mifeprex.*

After *Mifeprex*:

You can become pregnant again soon after your pregnancy ends. If you do not want to become pregnant again, start using birth control when we advise you to. You should discuss any questions about birth control with our staff as we will have the most specific information about your situation.

CENTER FOR WOMEN'S HEALTH

MEDICATION GUIDE for *MIFEPREX*® (mifepristone)

Read this information carefully before taking *Mifeprex*. It will help you understand how the treatment works. This **MEDICATION GUIDE** does not take the place of talking with Dr. Nauser.

WHAT IS *MIFEPREX*?

Mifeprex is Taken to End an Early Pregnancy. It blocks the hormone **progesterone** needed for your pregnancy to continue. It is not approved for ending later pregnancies. Early pregnancy means it is **69 days** (9.6 weeks) or less since your last menstrual period began. At the time of your office visit you will take 200mg of Mifeprex (**Day 1**). You will also take another medicine, *misoprostol*, **2 days** later (**Day 3**), to cause your body to expel the dead pregnancy tissue. About 2-7 out of 100 women taking *Mifeprex* will need a surgical procedure (D&C) to complete the process, or to stop excessive bleeding.

What Information Should I Know About *Mifeprex*?

Cramping and bleeding are an expected part of ending a pregnancy. Rarely, serious bleeding, infections, or other problems can occur following a miscarriage, surgical abortion, medical abortion, or childbirth. Prompt medical attention is needed in these circumstances. Serious infection has resulted in death in a very small number of cases; in most of these cases misoprostol was used in the vagina. Nothing indicates that use of *Mifeprex* or oral *misoprostol* caused these deaths. If you have any questions, concerns, or problems, or if you are worried about any side effects or symptoms, you should contact our office: (913) 491-6878.

Be Sure to Contact Our Office Promptly If You Have ANY of the Following:

- **Heavy Bleeding**: Contact us right away if you soak through 2 (two) thick full-size sanitary pads per hour for 2 (two) consecutive hours; or, if you are concerned about heavy bleeding. In about 1 out of 100 women, bleeding can be heavy enough that it requires a surgical procedure (**surgical abortion/D&C**) to stop it.
- **Abdominal Pain or "Feeling Sick"**: If you have abdominal pain or discomfort; or, you are "feeling sick", including weakness, nausea, vomiting or diarrhea, with or without fever, more than **24 hours** after taking misoprostol, you should contact our office without delay. These symptoms may be a sign of a serious infection or another problem (including an **ectopic pregnancy**, a pregnancy outside the uterus).
- **Fever**: In the days after treatment, if you have a fever of **100.4° F** or higher that lasts for more than **4 hours**, you should contact your provider right away. Fever may be a symptom of a serious infection or another problem (including an ectopic pregnancy).

Keep this MEDICATION GUIDE with you. If you are told to visit an emergency room or a provider who did not give you the *Mifeprex*, you should give them this **MEDICATION GUIDE** so that they understand that you are having a medical abortion with *Mifeprex*.

What to do if you are still pregnant after *Mifeprex*. If you are still pregnant, we will talk with you about your other choices, including a surgical procedure (D&C) to end your pregnancy. You have signed a **Consent Form** agreeing to complete the abortion process if the medication fails. There is a chance that there will be birth defects if the pregnancy is not ended.

Before you take *Mifeprex*, you should read this **MEDICATION GUIDE** and sign the **Consent Form**. You and your doctor will discuss the benefits and risks of your using *Mifeprex*.

DO NOT TAKE *MIFEPREX*:

- If it has been more than **9 weeks 6 days** since your last menstrual period began.
- If you do not agree to return for the Day 14 visit.
- **If You Do NOT Agree to End the Pregnancy if the Medication Does Not Work.**
- If you have an **IUD**. It must be taken out before you take *Mifeprex*.
- If your doctor has told you that you have a pregnancy outside the uterus (ectopic pregnancy).
- If you have problems with your adrenal glands (chronic adrenal failure).
- If you take a medicine to thin your blood.
- If you have a bleeding problem.
- If you take certain steroid medicines.
- If you cannot easily get emergency medical help in the 2 weeks after you take *Mifeprex*.
- If you are allergic to *mifepristone, misoprostol* or medicines containing *misoprostol* (such as *Cytotec*)
- If you have porphyria.

HOW DO I TAKE MIFEPREX?

"DAY 1" (at our office):

- Read this **MEDICATION GUIDE**.
- Discuss the benefits and risks of using *Mifeprex* to end your pregnancy.
- If you decide *Mifeprex* is right for you, sign the **PATIENT CONSENT FORM FOR "MEDICAL ABORTION."**
- After getting a sonogram, swallow **1 tablet** (200mg) of *Mifeprex*.

2 days later (at your home) – This is called "DAY 3"

- Take **4 *misoprostol* tablets sublingually** (under the tongue), and swallow 30 minutes later.
- *Misoprostol* may cause cramps, nausea, diarrhea, chills and other symptoms.
- Doctor Nauser may write you a prescription for these symptoms.

"DAY 14" (at our office):

- You must return to our office **14 days** after you have taken *Mifeprex* to be sure you are well and that you are no longer pregnant.
- We will check whether the pregnancy has completely ended. If it has not, there is a chance that there will be birth defects. If you are still pregnant, you have agreed to end the pregnancy. We will talk with you about the choices you have, including a surgical procedure (**D&C**) to end the pregnancy.

What Should I Avoid While Taking *Mifeprex* or *Misoprostol*?

Do not take any other prescription or non-prescription medicines (including herbal medicines or supplements) at any time during the treatment period without first asking us, because they may interfere with the treatment. Ask us about what medicines you can take for pain.

What Are the Possible Side Effects of *Mifeprex*?

Cramping and bleeding are expected with this treatment. Usually, these symptoms mean that the treatment is working. But sometimes you can get cramping and bleeding and still be pregnant. This is why you must return to our office on **DAY 14**. If you are not already bleeding after taking *Mifeprex*, you probably will begin to bleed once you take *misoprostol*, the medicine you take on **DAY 3**. Bleeding or spotting can be expected for an average of 14 days and may last for up to 28 days. Your bleeding may be similar to, or greater than, a normal heavy period. You may see blood clots and tissue. This is an expected part of ending the pregnancy. Other common symptoms of treatment include diarrhea, nausea, vomiting, chills, headache, dizziness, back pain, and tiredness. These side effects lessen after **DAY 3** and are usually gone by **DAY 14**.

Doctor Nauser will tell you how to manage pain or other side effects. Call our office for medical advice about side effects: **(913) 491-6878**

WHEN SHOULD I BEGIN BIRTH CONTROL?

You can become pregnant again soon after your pregnancy ends. If you do not want to become pregnant again, start using birth control when advised by our staff.

CENTER FOR WOMEN'S HEALTH
Traci L Nauser, MD, FACOG
4840 College Blvd
Overland Park, Kansas 66211

(913) 491-6878 (24 Hours)

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)