DOCTOR: DR. CHANG

PATIENT ENCOUNTER FORM

□ New Patient	□ First Trimester	□ Follow Up	□ IUD Insert □ Medical
□ Established Patient	□ Second Trimester	□ Consultation	□ Depo Injection

LMP: ____/____/_____

□ Glucose	□ Urine Pregnancy	□ Wet Mount	□Quant HCG
□ Hemoglobin	□ Serum Pregnancy	□ ECP	□ Birth Control
□ Rh	□ HCG 2 IU	□ Sonogram A, V, B	□ Sono Guidance

Medications:

□ Conscious Sedation	□ Narcan 0.4 mg	□ Miso ____mcg Time_____
□ Nubaine ____mg	□ Fentanyl 50mcg ____mg	□ Miso ____mcg Time_____
□ Romazicon 0.2 mg ____mg	□ Lidocaine	□ Xanax 1mg Time ____#___
□ Zofran 4 mg ____mg	□ Pitressin 4 u	□ RU486
□ Methergine 0.2mg	□ Rhogam 50/ 300 u	□ Doxycycline 100mg #6/#14
□ Benadryl 25mg	□ Digoxin ____mcg	□Other:_________
□ Toradol 30mg IV/IM	□ Phenergan 12.5mg	□Ibuprophen 800mg Time _____
□Toradol 10mg PO	□ Acetaminophen 1gm	□Mirena/Paragard/Implanon
□Azithromycin 500 mg Time_______		

□ DO NOT SEE REASON: ________________	□ Self Pay $ _________ Cash/ Credit	□ Insurance Type: _________ Copay: $ _______ Cash/ Credit	□ Patient Refunded Amount : $ ________ □ Patient money kept

NOTES:

□ Patient too far/early
□ Patient not pregnant
□ Patient hemoglobin too low
□ Patient changed her mind

BP:___________Pulse:______
Temp:_________________
Weight:________________
Note:___________________
____

Gynemed Surgical Center - 17 Fontana Lane, Suite 201 - Baltimore, MD 21237

DOCTOR: DR. CHANG

[1] *Patient Registration Form & Consent for Medical Treatment*

First Name________________________________ MI____________ Last Name______________________________________

Birth Date_________________________________ **SS#**_____________________________ **Marital Status**_______________

Street Address____ Apt #_________________

City____ State___________________________ Zip Code_________________

Race______________________________________

Home Phone________________________ Work Phone__________________ Ext________ Cell phone __________________

Employer____ Occupation____

Insurance Carrier____________________________ Plan Type: ________________ Policy Holder______________________

Relationship____________________ Policy #____________________________ Group #______________________________

Secondary Insurance Information ____

Emergency Contact Name & Phone #: ____

REQUEST FOR MEDICAL TREATMENT

I request that Gynemed Surgical Center provide me with medical treatment. If the clinicians at Gynemed Surgical Center are unable to provide me care for the symptoms that I present, they will provide me with a referral to an appropriate provider.

I have completely and accurately disclosed my medical history including: allergies, current medical treatment, surgical history, and any medications or other drugs previously or current being used.

I consent to all applicable testing that is a necessary part of my care. This includes blood drawing, ultrasounds and collection of specimens for evaluation.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical care.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

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I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and I may need to be referred to another health care facility to provide the services necessary for my care.

I understand that any personal belongings such as; money, jewelry, cell phones, wallets etc... That are lost or stolen, Gynemed Surgical Center will not be held responsible. Please leave personal belongings with driver.

I understand that confidentiality will be maintained as described in Gynemed Surgical Centers *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*. I acknowledge receipt of Gynemed Surgical Center's notice of health information practices.

I hereby request that a person authorized by Gynemed Surgery Center provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

The *Patient Rights and Responsibilities*, including the facilities policy on advance directives, were made available to me at least 24 hours prior to my scheduled appointment.

Signature of patient ____

Date ________________

Signature of witness Amanda C. (Electronic Signature)______________

Date _____

Signature of legal guardian (if applicable)____

DOCTOR: DR. CHANG

Financial and Insurance Billing Policy

Patient with active health insurance coverage through a carrier with whom this practice contracts must have their benefits verified before each visit. Third-party billing is offered with the following conditions:

1) **Full estimated co-payment, co-insurance, and any unmet deductible are due at the time of service according to posted payment policies. The estimated co-payment, co-insurance, or unmet deductible may not be the actual charge once the claim has been processed by the insurance carrier. Patients may receive a refund for over-payment or a balance bill.**

2) **Patients must provide insurance card and photo identification at each visit.**

3) **Patients are fully responsible for obtaining any necessary referral before the appointment time.**

Although the practice staff makes every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will fully or partially pay a claim. The insurance carrier makes the payment determination, based upon the plan's level of coverage and associated policies, upon receiving the claim.

I hereby request the direct payment of medical benefits be made to David M. O'Neil, M.D. and Gynemed Surgical Center (which are two separate entities) for any services rendered to me. I authorize any holder of medical information about me to release this information to my insurance carrier or its intermediaries, to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I understand that because these services are performed for me, I am financially responsible for all charges whether or not paid by my insurance carrier. If payment is fully or partially denied, I understand that my insurance carrier expects the practice to bill me directly for services rendered, and I agree to be personally and fully responsible for payment. If I fail to pay the balance of my account in a timely manner, I understand that my account may be turned over to a collections agency. I agree to pay all costs associated with this action including collection fees, attorney fees, and court costs.

Patient Signature: ______________________________ Date: ______________

Gynemed Surgical Center Schedule of Common

CPT Code	Description	Charge	CPT Code	Description	Charge
99203	Office Visit	95.00	59840	Surgical D & C	500.00
76830	Sonogram, TV	90.00	56302		
36415	Venipuncture	25.00	-----	Facility Fee	850.00
86901	Rh Typing	15.00	99212	Follow-Up Visit	45.00
90782/J2790	RhoGam injection	140.00			

The actual amount paid by an insurance carrier will be based upon the plan's coverage level and contracted fee schedule. Please refer to your Explanation of Benefits (E.O.B.) for payment information.

DOCTOR: DR. CHANG

INFORMATION FOR SELF-PAY PATIENTS

In order to make our services accessible to patients lacking health insurance coverage, our practice offers a significant discount for self-pay patients. We offer our surgical abortion service at a discounted package price that includes transvaginal sonogram, blood testing and RhoGam injection for Rh negative patients, surgical procedure with IV sedation, antibiotics, and birth control pills if appropriate. Patients are assumed to have had a positive pregnancy test before their appointment for surgical abortion. Patients are responsible for calling Gynemed to schedule their follow-up appointment for approximately two weeks after their procedure.

(Gestation determined by sonogram at Gynemed Surgical Center)

Up to 12.0 weeks LMP	$360.00	17.1 – 18.0 weeks LMP	$1035.00
12.1 – 14.6 weeks LMP	$360.00	18.1 – 19.0 weeks LMP	$1440.00
12.1 – 14.6 weeks LMP with twins	$540.00	19.1 – 20.0 weeks LMP	$1620.00
15.0 – 16.0 weeks LMP	$720.00	20.1 – 21.0 weeks LMP	$2000.00
16.1 – 17.0 weeks LMP	$860.00	21.1 – 22.0 weeks LMP	$2200.00

Second trimester second day NO SHOW fee (No Show on surgery day)	$125.00
Medical abortion for those less than 10weeks LMP	$390.00
Follow-Up Visit (after 10 days)	$45.00

*** Note: Patients with health insurance coverage will never pay more than the discounted package price, regardless of liability indicated by their insurance carrier.**

<u>In the event the procedure is not performed for whatever reason or circumstance, patients will be charged for any of the following services that are performed.</u>

Transvaginal sonogram	$90.00	Physician Exam / Consult	$75.00
Abdominal sonogram	$90.00		
Blood draw / testing	$25.00	Urine pregnancy test	$10.00 FREE ON MON & THURS
Staff Consultation	$30.00	Serum pregnancy test	$25.00

Note: Any laboratory work performed outside of Gynemed Surgical Center (including, but not limited to HCG quantitative pregnancy tests) will be billed by the outside laboratory. Gynemed Surgical Center has no involvement with laboratory billing.

Self-pay patients who later wish to submit a claim to their insurance carrier should contact Gynemed Surgical Center which will submit the claim on the patient's behalf based upon the regular fee schedule. The patient will receive the appropriate refund if and when the practice receives reimbursement from the insurance carrier.

Patient Signature: ____ Date: ______________________________

DOCTOR: DR. CHANG

Consent for Purposes of Treatment, Payment, and Healthcare Operations

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Gynemed Surgical Center

Although this form is no longer required for HIPPA compliance, you are being asked to sigh this form because it is either required for state or other compliance. If you have any questions about this form please contact our present Office Manager.

CONSENT

I consent to the use or disclosure of my protected health information by Gynemed Surgical Center for the purpose of diagnosing me or providing treatment to me, for obtaining payment for my health care bills, or to conduct the health care operations of this organization. I understand that diagnosis or treatment of me by my physician may be dependent upon my consent as evidenced by my signature on this document.

RESTRICTION ON THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I understand that I have the right to request that this organization restrict the way my protected health information is used or disclosed in order to treat me to obtain payment or for the other healthcare operations of the organization. The organization is not required to agree to the restrictions that I may request, but if the organization does agree to a restriction that I request, the restriction is binding on the organization and on the staff.

REVOKE CONSENT

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician or this organization already has taken action based upon this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION

My "protected health information" means health information, including my demographic information such as but not limited to my age, my occupation, and the address at which I live, collected from me and created or received by my physician, another health care provider, a health plan, my employer, a health care clearinghouse, or any other entity that uses or creates health information about and that has a business relationship with this organization. This protected health information relates to my past, present or future physical or mental health or condition and either identifies me, or there is a reasonable basis to believe that the information might identify me. It does not include certain education records covered by the Family Education Rights and Privacy Act and records held by a covered entity in its role as an employer those exclusions may not apply to you as a patient of this practice.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES

I understand that I have the right to review this organization's Notice of Privacy Practices before I sign this consent document. That document has been provided to me. The Notice of Privacy Practices describes the way my protected health information will be uses or disclosed during my treatment, during the payment of my bills, or during the performance of the health care operations of this organization. The Notice of Privacy Practices for this organization is provided in the Waiting Area. This Notice of Privacy Practices also describes my rights and this organization's duties with respect to my protected health information.

Gynemed Surgical Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices by accessing the organization's website, calling or faxing the office and requesting that a revised copy be sent to me in the mail, or by asking for a revised notice at the time of my next appointment.

____

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Description of Representative

DOCTOR: DR. CHANG

INFORMED CONSENT for SURGICAL ABORTION

Initials

______ I, ________________________, am ____ years old, and was born on ________________. I hereby request and consent to have a surgical abortion by the providers of Gynemed Surgical Center. I fully understand that the purpose of this procedure is to end my pregnancy. This is my personal decision, and no one has coerced me or compelled me to make this decision.

______ I understand that the alternatives to the abortion procedure are parenting and adoption. I also understand that if I am less than 9 weeks that I can choose a medical abortion as an alternative to a surgical abortion. I choose a surgical method for my abortion.

______ ***I am under eighteen years of age.***
I understand that if I require emergency hospital treatment, my parent(s) or legal guardian may be contacted.
Name of parent / legal guardian: ____

Street Address: ________________________________ *City / State:* _________________

Telephone Number: ________________________________

Gynemed Surgical center encourages young women to discuss their pregnancy and options with a parent, relative or trusted adult. Under 1992 state law, the parent(s) of women under age 18 must be notified before an abortion is performed, unless specific conditions exist (see below).

Parent has accompanied their minor daughter to Gynemed Surgical Center and acknowledges minor's abortion decision.
Parental Acknowledgement: I hereby acknowledge that I am fully aware that my daughter has requested an abortion and that the physician intends to perform an abortion.

Signature of parent / legal guardian: ______________________________ *(relationship :____________________)*

In Accordance with Maryland State Law, minor's **parent has not been notified** of patient's intention to have an abortion because:

- The minor is mature and capable of giving informed consent to an abortion
- Notification would not be in best interest of minor
- Notice may lead to physical or mental abuse of minor
- Minor patient does not live with parent or guardian

Minor Patient's Signature________________________

Witness Signature________________________________

Physician's Signature _________________________

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_______ I understand that a surgical abortion is a very safe procedure but there are risks with any medical procedure. I understand that risks may be higher if I have had a C-section, multiple pregnancies or abdominal surgery. I understand that complications with surgical abortion are uncommon but could include the following**:**

- **Laceration (tearing) of the cervix**: A small tear in the cervix that may require stiches.
- **Continuing pregnancy:** Which may be due to multiple pregnancies, double uteri, or ectopic pregnancy. A second procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
- **Incomplete abortion:** There may be tissue left inside the uterus which may cause bleeding or infection. A second suction procedure may be required.
- **Hematometra**: A collection of blood in the uterus. It may require medications or a second suction procedure.
- **Infection**: Which may require antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
- **Perforation:** Sometimes the instruments may go through the uterus which may include damage to internal organs (bladder and bowel). Hospitalization may be required and surgery may be necessary. Rarely, it may be required to remove the uterus which will result in infertility.
- **Hemorrhage**: Heavy bleeding which may require further evaluation and treatment including a possible blood transfusion. Rarely, the uterus may have to be removed.
- **Reaction to anesthesia and/or medications:** resulting in shock, convulsions, or death.
- **Emotional problems**: Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feelings or provide appropriate referrals.
- **Scar tissue**: Scar tissue can occur in the cervix which is called cervical stenosis and may require repeat dilation. Scar tissue in the uterus is referred to as Asherman's Syndrome and may result in the inability to have children.
- **Death**: There is a risk of death with any surgical procedure. The risk of death from an abortion is very rare. The risk increases the longer you are pregnant. The risk of death from a full term pregnancy or childbirth is higher.

______ I consent to the administration of Misoprostol (Cytotec), whose purpose is to soften and dilate my cervix to facilitate the abortion process. I understand that Misoprostol can cause cramping, nausea, vomiting, diarrhea, and /or vaginal bleeding. I understand that Misoprostol can cause birth defects and once I take the medication, I am agreeing to complete the surgical abortion.

______ I understand that Gynemed Surgical Center may provide me with ONE of the following medication as needed post procedure for pain; Motrin 800mg, Tylenol 1000mg, and Naproxen 500mg.

______ I understand that I will be offered Alprazolam 1mg (Xanax) for anxiety. I understand that I have the right to deny this medication. I understand that this medication may make me feel drowsy. I also understand that once taking this medication I should not leave the building.

______ I understand that no guarantees about my future fertility can be offered to me, and no such guarantees have been made to me. I understand that there is evidence that women who have more than three induced abortions may be at increased risk for premature labor.

DOCTOR: DR. CHANG

______ I understand that the products of conception will be removed during the abortion, and I consent to their disposal by Gynemed Surgical Center in a manner they deem appropriate.

______ Do you currently have a **Living Will** or **Advanced** Directives in place, **YES OR NO** Please be advised that Gynemed Surgical Center does **NOT HONOR LIVING WILLS or ADVANCED DIRECTIVES**.

_______ I consent to the exchange of medical records between Gynemed Surgical Center and any other provider, physician, hospital, or clinic pertaining to my medical treatment.

_______ I agree to follow the instructions given to me regarding post-operative care and I agree to return for a follow-up visit. I agree to call Gynemed Surgical Center regarding any questions or problems that arise after my abortion procedure.

In the event of an emergency, I authorize the physician at Gynemed Surgical Center to provide emergency care using his / her medical judgment, including transfer to a local hospital. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary.

In the event of an emergency, I authorize Gynemed Surgical Center to contact the following individual:

Name: ______________________________ Relationship: ____________________

Street Address: ________________________ City / State: ____________________

Telephone Number: ___________________________

______ I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand such complications can be caused by my own condition or conduct and through no fault of the physician.

______ I understand Gynemed Surgical Center has the right to refuse me services for whatever reason they deem appropriate.

I have read and understand the above information including PATIENT RIGHTS AND RESPONSIBILITIES. I understand the above risks and accept these risks. I consent and request that a surgical abortion be performed.

Patient Signature: ________________________________ Date: ______________________________

Physician Signature: DChang MD (Electronic Signature) Date: ________________________

Witness Signature: Amanda C. (Electronic Signature) Date: ________________________

Translator Signature: ______________________________ Date: ______________________________

DOCTOR: DR. CHANG

Informed Consent for Moderate Sedation

Our aim is to make your procedure as comfortable as possible. In addition to moderate sedation, your options for pain relief during your procedure include: Local anesthesia which is a numbing medication injected into your cervix to decrease the pain of the opening of your cervix. Mild Sedation which is a pill to decrease your anxiety.

Moderate sedation is the administration of medications to help you relax and decrease the pain of the abortion procedure.

The medications we use include both oral and intravenous medications. You will be given a pill called alprazolam that will help you relax and enhance the effects of the injectable medications. Immediately prior to your procedure, you will be given remifentanyl, which is a pain medication, and midazolam, which is a medication to help you relax.

During the procedure, you will be awake and able to respond to our instructions. The medications will cause you to feel sleepy and decrease the pain of the procedure. Occasionally, the medications may give you an amnesia effect and you may not remember what happened during or immediately after the procedure.

The risks of moderate sedation include: failure to decrease discomfort, severe allergic reaction, phlebitis (inflammation of a vein), respiratory depression or arrest, cardiac arrest, stroke, death

The medications may also cause some side effects, which include: drowsiness, dizziness, amnesia, decreased coordination and mental function, decrease in inhibitions, nausea, vomiting, discomfort during injection

Our staff is trained in the administration moderate sedation` and in emergency procedures. You will have qualified staff monitoring your vital signs and level of consciousness until it is safe for you to be discharged.

You must have a responsible adult to escort/drive you home from the facility today. Also, for the next 12-24 hours, you **must not** drive, operate machinery or make important decisions.

I, ___________________________________, give voluntary consent for the physicians of Gynemed Surgical Center to provide me with moderate sedation. I have been informed of the benefits, risks, and side effects of the medications being used. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have discussed with my clinician all medications and/or substances used within the last 24 hours. I have not had anything to eat or drink in the last 8 hours.

____ ____________________

Patient Signature Date

Amanda C. (Electronic Signature) ____________________ ___________

Witness Date

____ ____________________

Interpreter Date

DOCTOR: DR. CHANG

COMBINED HORMONAL CONTRACEPTIVE METHODS (CHCM) CONSENT FORM

This fact sheet explains the good things and the possible problems of CHCM. If you do not understand all the information, or if you have any questions, please ask your clinician/counselor.

What is it? CHCM include the birth control pill, the birth control vaginal ring, and the birth control patch. They are safe and effective methods of birth control. They are methods which must be used correctly and consistently. You should choose one of these methods of birth control only after reading this fact sheet and discussing your birth control needs with a counselor.

How do CHCM prevent pregnancy?
Each of your ovaries contains thousands of unripe eggs. About half way between the start of one period and the start of the next period, an egg ripens and is released into the tube of the uterus. This is called ovulation. CHCM prevent this from happening. The hormones also thicken your cervical mucus so sperm are not able to swim through it.

Who may take CHCM? Most women can safely use these methods throughout their reproductive years as long as they do not have specific medical problems which would create a health risk.

Who should not take CHCM?
You should not use these methods if:

- you are or suspect you may be pregnant
- you have abnormal vaginal bleeding that has not yet been evaluated
- you presently have serious liver disease
- you have ever had any kind of growth in the liver
- you are being treated for or have a history of cancer in the breast
- you have a lump in the breast that has not yet been evaluated
- you are being treated for or have a history of any estrogen-dependent cancer

  you are being treated for blood clots in the body or have a history of every having a blood clot/hypercoagulability (Known thrombogenic mutations (e.g. Factor V Leiden, Prothrombin mutation, Lupus Anticoagulant, Protein C, Protein S and Antithrombin deficiencies)
- you have ever had a stroke
- you are 35 years of age or older and you smoke cigarettes
- migraine with aura or neurological change

If you now have or have had a health problem such as migraine headaches, heart disease, high blood pressure, diabetes or gallbladder disease, or are a heavy cigarette smoker, tell your clinician so that she or he may decide if it is safe for you to take these methods. Each of these problems can be made worse by the use of CHCM.

It is known that if a woman smokes cigarettes while using CHCM, she is at higher risk of medical problems. Therefore, women who use these methods are advised not to smoke.

COMMON PROBLEMS

CHCM can have side effects in some women. Fortunately, the side effects are usually not serious. While taking these methods the following problems could occur:

MINOR PROBLEMS

- nausea
- spotting between periods
- less menstrual bleeding
- breast tenderness
- weight gain
- headaches
- depression
- high blood pressure
- darkening of the skin or face
- worsening of acne
- hair loss or increase in hair growth
- decreased sex drive

MAJOR PROBLEMS

- blood clots of the leg or lung (risk is less than that of being pregnant)
- stroke or heart attack
- liver tumors
- gallbladder disease

How effective are CHCM? If CHCM are used perfectly (as directed and other instructions are followed), only about 1 in 1,000 women may become pregnant within the first year. CHCM are only effective while you are taking them. As soon as you stop taking these methods you are no longer protected from pregnancy
.

DOCTOR: DR. CHANG

BENEFITS

Many women experience the following benefits from using these methods:

- decreased menstrual cramps
- decreased menstrual bleeding
- more regular menstrual bleeding
- decreased pain at the time of ovulation
- improvement in acne
- less risk of developing ovarian and/or endometrial cancer
- less risk of developing benign breast tumor and/or ovarian cysts
- some women note a reduction in PMS

REPORT ANY NEW OR UNUSUAL MEDICAL PROBLEMS TO YOUR CLINICIAN RIGHT AWAY

Other medical drawbacks and risks:

- Between 1% and 2% of women will not menstruate for 6 months or more after stopping CHCM. If you do not have your period, return to the clinic for a pregnancy test.
- If your periods are irregular prior to taking pills, they may again become irregular after you stop these methods.
- The estrogen hormone in these methods slightly decreases the quality and quantity of breast milk. Some experts advise against CHCM while breast feeding if other options are available.
- Lack of protection against STDs. While CHCM are a highly-effective, convenient methods of birth control, they do not provide any protection against sexually transmitted infections such as gonorrhea, chlamydia, or HIV (the virus that causes AIDS). If you or any of your sexual partners have other partners, it is very important to use a latex condom every time you have sex in order to protect yourself against these infections.

PRECAUTIONS YOU SHOULD TAKE

Tell any health care provider that you see that you are using CHCM.

When using these methods, you should call your clinic right away if you have any of the following:

- numbness or severe headaches which are not tension headaches and are not relieved with aspirin
- severe leg pain (calf or thigh; usually one leg)
- severe chest pains, shortness of breath eye problems; blurred vision, flashing lights, or blindness
- severe abdominal pain

Please read each of the listed items below.

I understand the side effects, risks, and benefits in using combined hormonal contraceptives. I have also been explained other alternative methods of birth control.

I have read the above statement about Combined Hormonal Contraceptive Methods and have had the opportunity to ask questions.

I wish to receive a combined hormonal contraceptive method.

I understand the side effects and risks of using combined hormonal contraceptives while smoking and still request to receive CHCM.

Complete the spaces below.

Patient: Date___________________

Name (please print)_______________________________ Signature______________________________

Witness: I was present when this form was orally explained, in detail, to this client. To the best of my knowledge and belief, this client understands the information contained in this form. If the client is a minor, I have assessed the client's conduct and sexual relationships and I believe the client to be a mature minor.
Date ______________

Signature: Amanda C. (Electronic Signature)________________________

DOCTOR: DR. CHANG

Please mark the concerns you have today:

____ I don't understand how an abortion is done
____ I'm wondering how I'll feel after
____ I'm not sure of my decision
____ I'm worried about how to avoid getting pregnant again
____ I'm afraid people will find out / judge me
____ I know I will regret the abortion
____ I'm worried I won't be able to get pregnant when I want to
____ Will this hurt?
____ My relationship with my partner or family
____ Possible complications during and after the abortion
____ I don't have anyone to talk to about it
____ Other: ____

1. Circle all the words that describe how you feel:

Sad	Happy	Angry	Trapped	Confident
Lost	Nervous	Selfish	Helpless	Irresponsible
Mean	Comfortable	Worried	Nauseated	Disappointed
Scared	Powerful	Relaxed	Ashamed	Resolved
Hungry	Relieved	Numb	Guilty	

2. What is the name of the person who came with you today? ____________________

3. Was this decision difficult or easy for you? ____________________

4. Whose decision is it for you to have this abortion? ____________________

5. Have you discussed this decision with anyone? If so, whom? ____________________

6. Does the man involved know about your decision? If so, is he supportive? ____________

7. What are your thoughts about ending this pregnancy? ____________________

____

____

____

8. Have you had any difficult experiences with pregnancy in the past? ________________

____

____

DOCTOR: DR. CHANG

HEALTH HISTORY

Your complete and honest health history is necessary to provide you with the best medical care.

GENERAL HEALTH HISTORY (please explain all "yes" answers in the spaces provided)

Do you have any allergies? NO YES ____________________

Have you ever had a reaction to anesthesia? NO YES ____________________

Are you currently under treatment by any other doctor? NO YES ____________________

Are you taking methadone or suboxone? NO YES Dose____________________

Have you taken any prescription or any other drugs today or within the last week? NO YES ____________________

Have you taken any muscle relaxers, sleeping pills, pain pills or anxiety medications in the last year? NO YES

If Yes, please list medication, how many taken and length of use: ____________________

Do you smoke? NO YES How many cigarettes per day? __________ For how many years? ____________

Do you consume alcohol? NO YES How many drinks per week? ____________________

Please CIRCLE if you have ever, in the past or present, had any of the following:

Anemia	Epilepsy / Seizures	Sickle Cell Disease
Asthma / Hay fever	Emotional Problems	Shortness of Breath
Bladder / Kidney Infections	Gall Bladder / Appendicitis	Stomach Pain / Ulcers
Bleeding Problems	Frequent Headaches	Swollen Feet / Ankles
Blood Transfusion	Heart Murmur	Surgery
Blood Clots / Phlebitis	Hepatitis / Jaundice	HIV/AIDS
Cancer	High Blood Pressure	Fainting / Dizzy Spells
Chest Pain	Hospitalization	Drug Abuse/ Addiction
Diabetes	Rheumatic Fever	Stroke

Do you have any other health conditions of which we should be aware? NO YES

If Yes, please describe: ____________________

FAMILY HEALTH HISTORY

Please circle if any of your immediate family members (mother, father, brothers, and sisters) have ever had:

Blood Clots	Genetic problems	High cholesterol
Cancer	Heart Attack/ Heart disease	Osteoporosis
Diabetes	High Blood Pressure	Stroke

DOCTOR: DR. CHANG

GYNECOLOGICAL HEALTH HISTORY

Age of First Period: _______ Are you periods regular? YES NO Days of Flow: ___________________

Cramps: None Mild Moderate Severe Relieved by: ____

First Day of Last Menstrual Period: ____________________ Normal? YES NO

Have you ever had an internal pelvic examination? YES NO

Last exam / Pap smear: ________________ Was it normal? YES NO

Have you ever had an abnormal pap smear? NO YES When: _________ Treatment: ________________________

Have you ever tested positive for a sexually transmitted infection? YES NO

If yes, Please list the type of infection and when it occurred: ____

When was your last mammogram? ______________________Was it normal? ______________________________

PREGNANCY HISTORY

Number of previous pregnancies: _______________ History of twin / multiple pregnancies: NO YES

Number of live Vaginal births: _________ Month/Years: ____

C-Sections? ___________________Month/Years_____________Complications/Premature:_____________________

Number of miscarriages: ________ Month/Years: _____________________ D&Cs? __________________________

Number of abortions: ___________ Month/Years: _____________________ Any 12+ weeks? _________________

Number of ectopic pregnancies: _________ Month/Years: _________ Rupture? ______________________________

How many living children do you have? _________________

CONTRACEPTIVE HISTORY

Were you using contraception when you became pregnant this time? NO YES Type:________________________

Have you ever used any of the following birth control methods?

_____ Birth Control Pill _______ Nuvaring _______Patch _______ Depoprovera (Shot)

_____ Implanon/Norplant _______ Mirena _______ Paragard (copper IUD)

_____ Condoms _____ Spermicide ______ Diaphragm _____ Withdrawl

_____ Other: ____

What method of contraception do you plan to use in the future? ____

The patient's medical /surgical history reviewed by attending physician _DChang MD (Electronic Signature)

DOCTOR: DR. CHANG

Gynemed Surgical Center Medication Form

INSTRUCTIONS: Please provide us with any and all information regarding your use of prescription drugs, over (OTC) medications (e.g. Tylenol, Advil), dietary supplements, eye drops, nasal sprays etc that you are using on either a long or short term basis. If you are not taking any prescription medications or OTC medications leave the space below blank. (Please write on the back if you need more room)

If you are allergic to any medications please list them here (including latex):

- I do not have any allergies to any medication that I am aware of

____

Please list medications that you take daily:

Medication Name & Dose	Route (mouth, eyes, etc)	Frequency (How Often)	Last Dose Taken (Date & Time)

Reconciliation of Medication List- **FOR STAFF USE ONLY**

☐ **Medications listed above are okay to take with medication given to you from Gynemed.**

Medication Name & Dose	Route (mouth, eyes, etc)	Frequency (How Often)	Last Dose Taken (Date & Time)
☐			

Patient Signature: _________________________________ Date:_______________________________

Staff Signature: Amanda C. (Electronic Signature) Date: _______________________________

Physician Signature: Dr. Chang, MD (Electronic Signature) Date: ___________________________

DOCTOR: DR. CHANG

Gynemed Surgical Center Driver Verification Consent

Date:______________________ Name of my driver:____

Relationship: _________________________ His/her cell number:______________________________

IMPORTANT, Please read carefully.

If my driver has not accompanied me to my appointment than Gynemed Surgical Center will cancel my appointment. In the event that my driver is not present at the time of my discharge I will wait until my driver arrives. Upon my drivers arrival, he/she must come to the facility to pick me up in order for me to be discharged. If I need to take a taxi I must be accompanied by a trusted person who has come with me to my appointment.

I understand that I should not drive 24 hours following a surgical procedure. I understand that driving while medically intoxicated is viewed the same as driving under influence of alcohol and drugs. I understand that I can be arrested for driving while medically intoxicated. I understand that I can injure or worse, kill another person on the road while under the influence of medications.

I understand I will not be allowed to leave the office by myself, or drive a car. There will be no exceptions. I understand Gynemed Surgical Center will not perform any surgical procedure without confirmation of a driver.

I, _____________________________(print name), on my behalf and on behalf of my heirs, personal representatives, successors and assigns hereby release and hold harmless Gynemed Surgical Center from and against any claim for injury, including death, or loss or damage to my personal property that may be sustained by me during travel to my destination upon leaving the facility and 24 hours from departure of the facility. This release extends to any and all claims I have or may have against the release parties.

I hereby state and represent that

- I was not under the influence of any medication when I signed this agreement.
- I was of sound body and mind when I signed this release.
- I fully understand the risk and dangers inherent in driving within 24 hours of my procedure.
- I expressly agree to assume the entire risk of any personal injury, including death, which I might suffer as a result of driving within 24 hours of my procedure.

If any provision of this waiver and release shall be declared by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this waiver and release shall not be affected thereby and shall be enforced to the fullest extent permitted by law.

By signing below, I disclose that I have read, understand, and agree to the terms and conditions stated herein.

_______________________________ _______________________________

Signature of Patient Signature of Driver

DOCTOR: DR. CHANG

Gynemed Surgical Center Patient Follow-Up Information Form

The purpose of this form is to help us keep track of our patients after their procedure here in our office. Please provide the information listed below so that we may contact you in the coming days regarding your recovery. If you visit the hospital for any reason regarding your procedure, please inform our staff when they call so we may update our records (we may request copies of your hospital report). In the event you visit the hospital after we have the chance to talk with you, we would appreciate it if you still called and notified our office. If you have any questions please talk to any one of our staff. Thank you.

First Name:__________________ Last Name:__________________

Date of Procedure:____________________

Date of Birth:___________________

Are you having a surgical or medical ("Termination Pill") procedure? Surgical Medical

Last four Social Security numbers (for security and patient verification purposes):____________

Phone number where you can be reached: (_______)____________________________

Is it okay to leave a message if needed? Yes No

Although adverse incidents are rare following an abortion procedure, it is our goal to follow up with you personally to make sure that all of your healthcare needs are met. To ensure your health and safety, it is VERY IMPORTANT to schedule a follow up appointment as soon as possible if you have not already done so. Thank you very much for choosing ***Gynemed Surgical Center*** for your healthcare needs. We understand the importance and need for quality women's health care and strive to provide you with just that and more.

DOCTOR: DR. CHANG

For Administrative Purposes Only

Call Date:___________ Staff Initials:___________

Patient Reached? Yes No If no, was a message left? Yes No

If medical, was the pregnancy passed? Yes No N/A

Did the patient experience fevers over 100.4F? Yes No

Did the patient have any excessive bleeding that soaked more than two pads per hour? Yes No

Did the patient experience excessive pain that could not be eased with Tylenol or Ibuprofen? Yes No

Did the patient go to the hospital for any reason? Yes No

If yes, where and when?____

Any other issues following the procedure?

____

____

____

Do you have a follow-up scheduled? Yes No

If no, would you like to schedule one? Yes No

Staff Signature:_____________________________

How to Take Care of Yourself at Home

Your body will recover from the abortion very quickly. It is important to take good care of yourself once you are discharged from our care. This information sheet will provide you with guidance on this care.

Bleeding:

- The bleeding that is experienced after an abortion is very individual. It is normal to have no bleeding at all or a range of bleeding from very light to heavier than a normal menstrual period. Bleeding usually lasts 5-7 days but irregular bleeding may continue until your next menstrual period.
- It may take up to 5-8 weeks for your regular menstrual cycle to return.
- You may notice a discharge after your abortion that looks like coffee grounds or a small clump of tissue. This is Monsel's solution. It is used to control bleeding after the procedure.

Pain:

- It is normal to have mild discomfort after your abortion.
- You can use over-the-counter pain relievers for relief of the discomfort. Generally, Ibuprofen and naproxen sodium work very well for cramps. If you are unable to take that, acetaminophen is also an option. The amount depends on which medication you are using:
    - Ibuprofen 800mg every eight hours. Over-the-counter brands (Advil and Motrin) contain 200mg per pill. You can take four of the over-the-counter every 8 hours.
    - Naproxen Sodium 500mg every 12 hours. Over-the-counter brands (Aleve) contain 220mg. You can take two every 12 hours.
    - Acetaminophen 1000mg every 4-6 hours. Over-the-counter brands (Extra Strength Tylenol) contain 500mg per pill. Do not take more than 8 pills in a 24 hour period.
- You may have mild discomfort at the site of your IV. Warm moist compresses will help relieve the discomfort.

Diet:

- You may resume your normal diet. Please do not drink any alcohol for 24 hours.

Activity:

- Rest and light activity for the rest of today.
- You may return to your normal activity tomorrow. You may return to work or school.
- Do not do any heavy lifting or vigorous activity for one week.
- Please do not have sexual intercourse until your follow-up exam.

Hygiene:

- Do not take tub baths for 2 weeks. You may shower as often as you would like.
- Please do not use tampons or douche for the first two weeks after your procedure.

DOCTOR: DR. CHANG

Sedation precautions:

- The effects of the medications can last for up to 24 hours after your procedure. These feelings can include: sleepiness, blurry vision, unsteady gait, nausea and vomiting.
- Do not drive, operate heavy machinery or make important decisions for the next 24 hours.
- Do not take any medications that have a sedating effect. This includes: allergy medications, sleep aids, and prescription pain relievers.

Medications:

- You have been given antibiotics before the procedure to prevent infection. Some patients may receive antibiotics to take at home.
- Some patients may receive a prescription or antibiotics to take at home please follow instructions provided.
- You may be given birth control to start after your abortion. Please refer to the birth control fact sheet for those instructions.

Follow-up:

- It is important to return to our office for your follow-up visit. You can schedule this visit before you leave or call our office at your convenience.
- If you are unable to return to Gynemed for your follow-up, please schedule an appointment with your routine gynecologist for this care one week after your abortion.

Please contact us at 410-391-1000 immediately if you experience:

- Fever of 100.4 or greater.
- Soaking 2 maxi-pads an hour for more than 2 hours in a row.
- Passing blood clots larger than the size of a half-dollar.
- Severe pain that is not relieved with pain medication.

If you are unable to contact us and feel like you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency.

I understand the above information regarding my care. I have had the opportunity to ask questions. I am being discharged to a responsible adult who will drive me home.

______________________________ _______________
Patient/Responsible Party Signature Date

Amanda C. (Electronic Signature) _______________
Staff Signature Date