

PATIENT ENCOUNTER FORM

<input type="checkbox"/> New Patient	<input type="checkbox"/> First Trimester	<input type="checkbox"/> Follow Up	<input type="checkbox"/> IUD Insert	<input type="checkbox"/> Medical
<input type="checkbox"/> Established Patient	<input type="checkbox"/> Second Trimester	<input type="checkbox"/> Consultation	<input type="checkbox"/> Depo Injection	

LMP: ____ / ____ / ____

<input type="checkbox"/> Glucose	<input type="checkbox"/> Urine Pregnancy	<input type="checkbox"/> Wet Mount	<input type="checkbox"/> Quant HCG
<input type="checkbox"/> Hemoglobin	<input type="checkbox"/> Serum Pregnancy	<input type="checkbox"/> ECP	<input type="checkbox"/> Birth Control
<input type="checkbox"/> Rh	<input type="checkbox"/> HCG 2 IU	<input type="checkbox"/> Sonogram A, V, B	<input type="checkbox"/> Sono Guidance

Medications:

<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Narcan 0.4 mg	<input type="checkbox"/> Miso ____ mcg Time ____
<input type="checkbox"/> Nubaine ____ mg	<input type="checkbox"/> Fentanyl 50mcg ____ mg	<input type="checkbox"/> Miso ____ mcg Time ____
<input type="checkbox"/> Romazicon 0.2 mg ____ mg	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Xanax 1mg Time ____ # ____
<input type="checkbox"/> Zofran 4 mg ____ mg	<input type="checkbox"/> Pitressin 4 u	<input type="checkbox"/> RU486
<input type="checkbox"/> Methergine 0.2mg	<input type="checkbox"/> Rhogam 50/ 300 u	<input type="checkbox"/> Doxycycline 100mg #6/#14
<input type="checkbox"/> Benadryl 25mg	<input type="checkbox"/> Digoxin ____ mcg	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Toradol 30mg IV/IM	<input type="checkbox"/> Phenergan 12.5mg	<input type="checkbox"/> Ibuprophen 800mg Time ____
<input type="checkbox"/> Toradol 10mg PO	<input type="checkbox"/> Acetaminophen 1gm	<input type="checkbox"/> Mirena/Paragard/Implanon
<input type="checkbox"/> Azithromycin 500 mg Time ____		

<input type="checkbox"/> DO NOT SEE REASON: _____	<input type="checkbox"/> Self Pay \$ _____ Cash/ Credit	<input type="checkbox"/> Insurance Type: _____ Copay: \$ _____ Cash/ Credit	<input type="checkbox"/> Patient Refunded Amount : \$ _____ <input type="checkbox"/> Patient money kept
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NOTES:

- Patient too far/early
 - Patient not pregnant
 - Patient hemoglobin too low
 - Patient changed her mind
- BP: _____ Pulse: _____
- Temp: _____
- Weight: _____
- Note: _____
- _____

ULTRASOUND

PATIENT INSTRUCTIONS for MEDICAL ABORTION

You have decided to have a medical abortion. The following instructions will help you guide the process at home.

IN THE OFFICE:

You have taken mifepristone (Mifeprex, RU486) in the office today. We do not expect you to have any side effects from this medication and you can continue your normal activities as planned.

AT HOME:

You have been given misoprostol (Cytotec) tablets to use at home to expel the pregnancy. The medications may cause side effects including: nausea, vomiting, diarrhea and fever. We will provide you with prescriptions of medications that will reduce the side effects and assist with comfort throughout the procedure.

30 minutes before inserting the misoprostol (optional):

- You can take one prochlorperazine (Compazine) tablet to prevent nausea.
- You can take one acetaminophen/codeine tablet to help with the discomfort.
- You can take 800mg of ibuprofen (4 of the over-the-counter strength) to help with the discomfort.

It is easier to prevent side effects than to get them to go away after they have started. You can use all or none of the above medications prior to starting the process. It is your choice.

8-48 hours after taking the mifepristone:

You have been given one set of four misoprostol (Cytotec) tablets.

- You need to put all four misoprostol tablets between your cheek and gums (2 on each side), let them dissolve for 30 minutes and then swallow them with water.
- You may want to put a maxi-pad in place prior to using the misoprostol.
- You should have someone with you to assist you if your symptoms are severe.

You can insert the misoprostol between _____ and _____

Antibiotics:

You have been given a prescription for antibiotics to prevent infection after the abortion. You should start the medication the day that you take the mifepristone in our office or before the misoprostol (4 tabs). Antibiotics are either:

- Azithromycin 500mg - take ONE tablets at once.
- Doxycycline 100mg – take 2 times a day for 7 days.
- Amoxicillin 500mg – take every 8 hours.

What to expect:

You will start to cramp and bleed approximately 1 to 4 hours after taking the Misoprostol tablets. The majority of patients will have heavy bleeding and pass the pregnancy tissue within 24 – 48 hours. Some women may have lighter bleeding for several days and then pass clots and pregnancy tissue.

Bleeding: You may experience bleeding that is much heavier than your normal menstrual period. You may also pass clots that may seem very large at times. The bleeding will decrease but may continue irregularly for until your next normal menstrual cycle.

Cramping: You may experience cramping that is much more intense than your normal menstrual cycle. You can use a variety of medications to be comfortable during the abortion process. These medications include:

DR: CHANG

- Ibuprofen 800mg (Motrin or Advil, 4 of the over-the-counter strength) every 8 hours or
- Naproxen sodium 500mg (Aleve, two of the over-the-counter strength) every 12 hours

- Tylenol #3, one or two every 4-6 hours

You may take Tylenol #3 with either the ibuprofen or naproxen sodium. Do not take ibuprofen and naproxen sodium together. Do not take extra acetaminophen (Tylenol) with the Tylenol #3.

Nausea and vomiting: It is normal to experience nausea and vomiting for up to 24 hours after taking misoprostol . You may continue using the prochlorperazine (Compazine) every 6-8 hours as needed for nausea.

Once you have begun bleeding:

- DO NOT put anything in the vagina for 2 weeks. No tampons, douching or sex.
- DO NOT take a tub bath or use a swimming pool or hot tub for 1 week
- Avoid heavy lifting (over 25 pounds) for 1 week

Contact our office: Please call our office at 410-391-1000 if you experience any of the following symptoms:

- No bleeding for 24hours after the misoprostol
- Soaking 2 maxi-pads an hour for more than two hours
- Fever higher than 100.4
- Abdominal pain or discomfort not relieved by pain medication
- Nausea, vomiting, chills, fever or diarrhea more than 24 hours after taking the misoprostol

If your symptoms are severe and you feel like you are experiencing a medical emergency, please call 911 or go to the nearest emergency room.

Birth Control:

Pills, patch and Nuvaring: You can start these birth control methods on the first Sunday after you use the misoprostol.

Depo-provera (the shot): We will give you a prescription to get the medication and you will bring it to our office and get the injection the day of your follow-up visit.

Nexplanon, Mirena and Paragard: We can place any of these methods on the day of your follow-up visit.

Follow-Up:

Your follow up appointment is extremely important to confirm that the abortion was complete. You should have a follow up appointment 1-2 weeks after taking the misoprostol tablets. Please return to Gynemed for your follow up visit. Your follow up visit is scheduled for _____

If you are unable to keep this appointment, please call us at 410-391-1000 to reschedule.

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.

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.

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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 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 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 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) _____

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	Charge	CPT Code	Description
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.

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 (within 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.**

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.

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: _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

Gynemed Surgical Center

Although this form is no longer required for HIPPA compliance, you are being asked to sign 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

INFORMED CONSENT for MEDICAL ABORTION

Initials

____ I, _____, am ____ years old, and was born on _____. I hereby request and consent to have a medical abortion by the providers of Gynemed Surgical Center. I fully understand the purpose of this process is to terminate 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 surgical abortion is an alternative to medical abortion. I choose the medical 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 _____

_____ I understand that a medical abortion is a very safe procedure, but like any medical procedure, there are risks. I understand that complication are not common but do include the following:

- **Continuing pregnancy:** 5 to 8 out of 100 women who have a medical abortion will still be pregnant after taking the medications. Continuing pregnancy may also be due to multiple pregnancies, double uteri, or ectopic pregnancy. A surgical procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
- **Incomplete abortion:** tissue left inside the uterus which may cause bleeding or infection. A surgical procedure may be required to empty the uterus.
- **Hematometra:** trapped blood clots in the uterus which may cause severe cramping and abdominal pain. A surgical procedure may be required to empty the uterus.
- **Infection:** including the fallopian tubes and ovaries. Infection is rare and occasionally hospitalization and antibiotics may be required. **Clostridium Sordellii** is a bacteria that has caused infections in women after medical abortion and in some cases these infections resulted in death.
- **Hemorrhage:** heavy bleeding which may require evaluation and/or hospitalization and further treatment. In rare instances a blood transfusion may be required.
- **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.

_____ I consent to the administration of misoprostol (Cytotec) and mifepristone (Mifeprex) to end my pregnancy. I understand that these medications cause cramping, nausea, vomiting and /or vaginal bleeding. I understand that these medications can cause birth defects and I agree to return to the center to confirm that the abortion was successful. I understand that if the abortion is not complete I will be required to have a surgical abortion.

_____ 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.

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 the instructions for the process including the importance of follow-up care. I have been given a printed copy of the discharge instructions. I agree to call Gynemed Surgical Center regarding any questions or complications I may have.

DR: CHANG

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 REPONSIBILITIES. I understand the above risks and accept these risks. I consent and have decided to take Mifeprex and Misoprostol to end my pregnancy.

Patient Signature: _____ Date: _____

Signature of Gynemed Surgical Center Witness: Amanda C.(Electronic Signature)

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 ever 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.

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

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.

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

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) _____

Gynemed Surgi-Center

NAME: _____ DATE: _____

When you choose to end a pregnancy at Gynemed Surgical Center, we consider both you physical and emotional health. Your responses to these questions help us provide you with the best possible care. We reserve the right to postpone or refuse our services to patients not deemed prepared for the abortion.

1) Please circle all words that describe how you feel:

Happy Sad Angry confident Guilty Scared

Confused Relieved Selfish Trapped Other _____

2) Are you sure of your decision to end this pregnancy?

3) What are the main reasons you have chosen to end this pregnancy?

4) Was this an easy or a difficult decision for you to make?

5) Have you discussed this decision with anyone? Have they been supportive?

Please check off the following items which concern you most today:

- ___ Not sure of your decision to have an abortion
- ___ Is this going to hurt?
- ___ Is this confidential?
- ___ Your relationship with your partner
- ___ Your relationship with your family
- ___ Will this affect future pregnancies?
- ___ Possible complications
- ___ Your religious beliefs or teachings
- ___ How you will feel after the procedure

In accordance with Maryland state law, upon my request I have received a list of agencies which could offer me assistance if I wanted to maintain my pregnancy.

Patient Signature: _____ Date _____

**ADDITIONAL INFORMATION REGARDING THE TREATMENT OF EARLY PREGNANCY WITH
MIFEPRISTONE**

Enclosed in this packet is additional information from the U.S Food and Drug Administration website regarding the use of Mifepristone for the termination of early pregnancy.

I, _____, have read and understood the FDA advisory regarding deaths associated with the medical abortion.

The FDA and the Provider of the Mifepristone have recommended 600 mg (#3 200 mg tablets) to be used for the termination of early pregnancy.

Since then, there have been sufficient studies that have proven that 200 mg of Mifepristone (#1 200 mg tablet) is just as effective as #3 tablets.

This will cut down on the cost of the procedure and the possible side effects associated with the medication. We recommend only #1 tablet (200 mg).

I, _____, accept the modification of the dosage of Mifepristone as recommended above by Gynemed Surgical Center.

Patient Signature: _____

Date: _____

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? _____

You will fill this part out during individual counseling with your counselor:

The following information has been discussed with the patient

___ The patient has considered all her options: abortion, adoption, and giving birth

___ The patient has made her own decision to have an abortion and expresses confidence in that decision

___ We discussed the procedure, aftercare, and prescriptions

___ We have discussed birth control methods

I, _____, have been informed of all the information listed above.
Patient Signature

I, _____, have discussed the above information with the patient.
Counselor Signature

Counselor Notes: _____

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 |

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 _D.Chang MD (Electronic Signature)_

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)
<input type="checkbox"/> AMOXICILLIN 500 MG	<i>By mouth</i>	<i>3x daily for 7 days</i>	<i>N/A</i>

Patient Signature: _____

Date: _____

Staff Signature: Amanda C.(Electronic Signature)

Date: _____

Physician Signature: DChang MD (Electronic Signature)

Date: _____

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.

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: _____