We extremely appreciate when patients bring in their completed paperwork at check-in. By completing your paperwork prior to coming to the office, we are able to process your information and get you back to a provider as close to your appointment time as possible.

The following pages must be filled out as completely as possible before being given to the front desk at check in.

Please make sure you have:

- Provided an emergency contact
- Filled out your insurance information (If self-pay, put that as your plan name)
- Signed each and every consent
- Fill out each page of the medical history completely.
    - If the question is not applicable to you, write n/a.
    - Only leave a question blank if you do not understand what it is asking
    - Supplements, vitamins, and consistently taken OTC medications (i.e. Advil, Flonase, Benadryl) should be listed under medications. A complete medication list is absolutely necessary at your appointment.
    - All allergies including seasonal, latex, food, and drug allergies should be listed
    - Any surgery you have had (including but not limited tonsillectomy, wisdom teeth removal, broken bone repair, etc.) should be listed with approximate date of procedure
    - If you are unable to remember exact dates of procedures such as surgeries or Pap Smears, please put you closest approximation

Thank you so much and please remember to bring a valid ID and Insurance Card to your appointment.

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME_____ SOCIAL SECURITY _____-_____-_____

ADDRESS _____CITY/STATE_____ZIP CODE_____

DATE OF BIRTH_____/_____/_____ MARITAL STATUS _____ RACE _____ETHNICITY_____

EMAIL _____ PRIMARY PHONE (CELL or HOME) (_____)_____

EMPLOYER _____WORK PHONE (_____)_____

EMERGENCY CONTACT _____ RELATION _____

CONTACT'S PHONE (CELL/HOME/WORK) (_____)_____

INSURANCE

PLAN NAME_____

ID NUMBER _____ GROUP NUMBER _____ PT RELATIONSHIP _____

POLICY HOLDER _____ _____POLICY HOLDER DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY NUMBER _____-_____-_____

SECONDARY INSURANCE (If applicable)

PLAN NAME_____

ID NUMBER _____ GROUP NUMBER _____ PT RELATIONSHIP _____

POLICY HOLDER _____ _____POLICY HOLDER DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY NUMBER _____-_____-_____

PERSON RESPONSIBLE FOR BILL OR PARENT (COMPLETE IF DIFFERENT FROM PATIENT)

GUARANTOR NAME _____ SOCIAL SECURITY NUMBER _____-_____-_____

RELATIONSHIP TO PATIENT (PLEASE CK): ( ) SELF, ( ) SPOUSE, OR ( ) PARENT DATE OF BIRTH_____/_____/_____

ADDRESS _____ PHONE NUMBER _____

EMPLOYER NAME _____ EMPLOYER PHONE NUMBER (_____)_____

EMPLOYER ADDRESS _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AND/OR

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in process insurance claims.

X_____

PATIENT OR PARENT (if a minor)

_____

DATE

To Our Patient

As you know, if you have ever checked into a hotel or rented a car the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company since it makes checkout easier, faster, and more efficient. We have implemented a similar policy. You will be asked for a credit card number at the time you check in and this information will be held securely until your insurance company has paid its portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you. We accept Visa, Mastercard, Discover and American Express.

Again, this will be an advantage for you since you will no longer have to write a check and mail it to us. It will be an advantage for us as well since it will greatly reduce the number of statements we have to generate and send out. This combination will benefit everyone, helping to keep the cost of health care down. In no way will it compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays due at this time of visit will, of course, still be due at that time.

If you have any questions about this method of payment, please do not hesitate to ask us.

Sincerely,

Baby Steps

I authorize Baby Steps to charge my credit card to pay any balances due on my account after my insurance company has processed my claim(s), or any balance owed to Baby Steps which would also include No show fees.

Print Name on Card:_____

Signature of Card Holder: _____Date Signed_____

Credit Card#:_____Exp._____
Security Code (on back of card)_____

Email address_____

DEBIT VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Consent for Treatment

As with any medical office, there is some risk involved in procedures and exams performed here. I hereby give consent to Baby Steps to provide whatever treatment the assigned medical provider may deem necessary to the patient named.

_____ _____

Patient/Responsible Party Signature Date

Consent for Treatment of a Minor

I authorize Dr. _____ and/or his/her staff to examine and/or treat my

_____

Indicate Relationship and First Name of Minor

_____ _____

Full Name of Child Date

_____

Signature of Responsible Part

IMPORTANT INFORMATION REGARDING INSURANCE BILLING:

Our doctors are here to provide you with the best medical care. Their primary concern is with your health and well-being, not with your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers. It is very important for you to read your insurance policy carefully. Some insurance companies do not cover annual gynecological visits while others will only cover certain specific problems. As we participate with numerous insurance companies and each company has many different plans, we cannot possibly be aware of each patient's coverage. We will bill your insurance company for exactly the procedures done in the office. You will receive a bill if the service is one that is not covered under your policy. It is very important that you are familiar with the benefits and policies of your insurance.

You will be asked at your visit which lab you would like Pap smears and cultures to be sent to and the nurses will note the name of the lab in your chart. It is very important that you check your insurance policy to see which lab they participate with. If the lab you choose is not participating with your insurance, the lab will bill you and you will be responsible for payment.

I have read the above and understand I am responsible for knowing the coverage and benefits of my insurance policy as well as choosing a lab that my insurance company participates with.

_____

Patient's Signature

_____

Date

FINANCIAL POLICY

Thank you for choosing us as your gynecologist/obstetrician. We are committed to providing you with quality and affordable health care. This is an agreement between Baby Steps and the Patient/Debtor named on this form. The word "account" means the account that has been established in your name to which the charges are made and payments are credited. The words "we" and "our" refer to Baby Steps. By executing this agreement, you are agreeing to pay for all services that are received. A copy will be provided to you upon your request.

Insurance: We participate in a variety of insurance plans. Please provide us with your most current insurance information at the time of each visit to prevent unnecessary claims denials. If you are insured by a plan we are not participating with, payment in full is expected at the time of each visit. We will gladly provide you with an itemized statement of charges that you can submit to your insurer. If you are unable to provide us with a current insurance card, payment in full is required for services rendered until coverage can be verified. KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY, PLEASE CONTACT YOUR INSURANCE PROVIDER WITH ANY QUESTIONS YOU MAY HAVE REGARDING YOUR COVERAGE.

Co-payments, Deductibles and Coinsurance: ALL co-payments, deductibles, and coinsurances must be paid at the time of service. This arrangement is part of our contract with our insurance provider. Failure on our part to collect co-payments, deductibles, and coinsurances from patients can be considered fraud. Please help us to comply with the law by paying co-payments, deductibles, and coinsurances each visit. THANK YOU.

Elective and Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered by your insurance provider. Elective and Non-covered services must be paid for in full at the time of your visit.

Proof of insurance: All patients must complete our Patient Information form PRIOR TO seeing the doctor. We must first obtain a copy of your VALID driver's license or state issued identification card and current valid insurance card so that coverage can be verified. Invalid or expired insurance information will result in the patient being responsible for payment of these services.

Claims Submission: If we are a participating provider with your insurance carrier, we will submit all claims and assist you in any way to assure all charges are paid on your behalf. At times, insurance carriers will request additional information from the patient before processing a claim. Please be aware that failure to supply this information could result in claims denial therefore leaving the patient responsible for payment in full.

Coverage changes: If your insurance changes, please notify us upon your arrival for your appointment to insure proper claims submission. It is your responsibility to confirm with your insurance carrier their laboratory of choice for any testing that may occur. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Missed Appointments: Our policy is to charge $25.00 for missed appointments not cancelled within 24 hours of your scheduled appointment time. New Patients who miss their first appointment will be subject to a "No Show" Fee of $40.00. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Returned Check Fee: There will be a $30.00 fee for checks written up to $300.00 or a $50.00 fee on checks written for $301.00 or over charged to your account for any returned items.

Divorce & Dependent Children: In case of separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing the treatment of the dependent child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Non-payment: If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account **IN FULL.** Partial payments will not be accepted unless other arrangements are made with our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer the collection of your balance to an attorney, you agree to pay all fees plus court costs incurred in the collection of the account. In case of suit, you agree that the venue be held in Daytona Beach, Florida.

Transferring of Records: You will need to request, IN WRITING, any transfer of medical records. You understand that you may receive one (1) complimentary copy of your medical file to be transferred to a new physician in the event that you transfer your medical care. Any additional requests will result in a charge of $1.00 per page up to 25 pages and $.25 per page for each additional page. You further understand that medical record requests from other entities, such as attorneys, etc. will all be subject to the same charges. In the event that these entities do not cover the required charges, you understand that the charges will become your responsibility. If you are requesting records to be transferred from another physician or organization, you authorize us to send all relevant information, including payment history.

Forms: Any forms filled out on your behalf will be subjected to a $20 fee per form, payable prior to picking up. We ask that you allow 7 days for processing.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____ _____

Signature of Patient or Responsible Party Printed Name Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Pamela P. Carbiener, MD., Chloe Singleton, APRN., Shameika Stalling-Favors, APRN., Anastasia Bobbe, MA. (from here on referred as Baby Steps Providers)** to use and disclose protected Health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices for **Baby Steps Providers** provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Baby Steps Providers** reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Helena Girouard, Privacy Officer, 421 S Keech Street, Daytona Beach, Florida 32114.*

With this consent, **Baby Steps Providers** may call my home or other alternative location and leave a message on voice main or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, **Baby Steps Providers** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confident."

I have the right to request that, **Baby Steps Providers** restrict how they use or disclose my PHI to carry out TPO. This request must be made in writing to the Privacy Officer. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this form, I am consenting to the use and disclosure of my PHI by, **Baby Steps Providers** to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, **Baby Steps Providers** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

_____ _____

Witness | Date

Dear Patient:

Thank you for the confidence you have placed in Baby Steps. Providers Pamela P. Carbiener, MD., Chloe Singleton, APRN., Shameika Stalling-Favors, APRN., Anastasia Bobbe, MA have arranged to care for each other's patients. It is our goal to offer continuity of care with one physician, however, there are times when that will not be possible.

If this is not a satisfactory arrangement, please let us know and we will discuss the matter.

Sincerely,

Baby Steps

I have read the above and agree to the arrangement for physician coverage.

_____

Patient's Signature

_____

Date

MEDICAL HISTORY

PLEASE CIRCLE/FILL IN ALL THAT APPLY

Cancer

-Hx of cancer, when and what kind(s)?_____

_____

Cardiac

-Arrhythmia
-High Blood Pressure
-Hx of Pre-Eclampsia
-High Cholesterol
-Other_____

Endocrinology

-Diabetes Type 1/Type 2
-Hx of Gestational Diabetes
-Thyroid Problems
-Other_____

GI

-Colon Polyps
-Crohn's/Ulcerative Colitis
-Gallbladder Disease
-Hemorrhoids
-Irritable Bowel Syndrome
-Liver Disease/Hepatitis
-Reflux/Stomach Ulcers
-Vitamin Deficiency
-Other_____

Hematology

-Anemia
-Bleeding Disorder
-Blood Clotting Disorder/Factor V Leiden
-Blood Transfusion
If yes, when? _____
-DVT/Pulmonary Embolism
-Other_____

Infectious Disease

-COVID 19
-Chicken Pox/Shingles
-HIV/Hep B/Hep C/Hep A
-MRSA
-Hx of Rheumatic Fever
-Tuberculosis/Positive PPD
-Other_____

Neurology

-Headaches/Migraines

-Neuropathy
-Seizures/Epilepsy
-Stroke/TIA
-Other_____

Ortho

-Chronic Back Pain
-Degenerative Joint Disease
-Fractures
-Osteopenia/Osteoporosis
-Other_____

Psych

-ADD/ADHD
-Anxiety
-Asperger's/Autism Spectrum
-Bipolar Disorder
-Depression
-Hx of Postpartum Depression
-Eating Disorder
-PMS/PMDD
-Other_____

Pulmonary

-Allergies/Allergic Rhinitis
-Asthma
-COPD/Emphysema
-Narcolepsy/Cataplexy
-Sleep Apnea
-Other_____

Rheumatology

-Arthritis
-Autoimmune Disease
-Fibromyalgia/Chronic Pain
-Other_____

Urology

-Chronic Kidney Disease
-Frequent UTIs
-Hematuria (Blood in Urine)
-Kidney Stones
-Urinary Incontinence
-Other _____

Weight Management

-Obesity
-Other_____

Other

-Hard of Hearing/Hearing loss/Deaf
-Speech Deficits
-Visual Deficits, Blindness

Any other medical conditions? Please list below:

_____

_____

_____

Primary Care Doctor: _____ **Phone #** _____

Address: _____

Preferred Pharmacy: _____ **Phone #** _____

Address: _____

Current Medications & Dosages (Include any over the counter medications, vitamins, or supplements)

_____

_____

_____

Drug Allergies (Include Drug Name & Reaction)

_____

_____

Social History: PLEASE FILL OUT COMPLETELY

SMOKING STATUS- YES NO FORMER **If yes/former, for how many years?** _____

How much? _____ packs per _____

VAPE/E-CIGARETTE USE? YES NO FORMER **If yes/former, for how many years?** _____

ALCOHOL INTAKE- None Occasional Moderate Heavy

CAFFEINE INTAKE- None Occasional Moderate Heavy

EXERCISE LEVEL- None Occasional Moderate Heavy

DIET- Regular Vegetarian Vegan Gluten Free Low Carb Cardiac Other_____

MARITAL STATUS- Single Married Divorced Widowed Domestic/Committed Partner

EDUCATION- _____

OCCUPATION- _____

Family History:

Please list any family history of heart disease, cancer, mental disorders, diabetes, breast or gyn problems.

Mother: _____ Father: _____

Maternal Grandmother: _____ Paternal Grandmother: _____

Maternal Grandfather: _____ Paternal Grandfather: _____

Siblings: _____

Other: _____

SURGICAL HISTORY Please list all surgical procedures and their year: _____

_____

_____

OBSTETRIC HISTORY

Total Number of Pregnancies (including miscarriages and terminations) _____

How Many were/are: Full Term_____ Pre-Term_____ Vaginal_____ C-Section_____ Living_____

Miscarriage_____ Abortion_____ Ectopic_____ Multiples_____

History of the following? (Check all that apply)

[ ] Pre-Eclampsia [ ] Gestational Diabetes [ ] Pre-Term Labor [ ] Emergency C-Section [ ] Postpartum Depression

[ ] Complications during Delivery, explain_____

_____

GYN HISTORY: PLEASE FILL OUT COMPLETELY

First Day of Last Period: _____/_____/_____ **Date of last Mammogram**: _____/_____/_____

Date of Last Colonoscopy: _____/_____/_____ **Date of Last Cologuard**: _____/_____/_____

Date of Last Bone Density: _____/_____/_____ **Date of last PAP:** _____/_____/_____

Result of last PAP: _____

Hx of abnormal PAP? (circle one) YES NO **If yes, what were the results?** _____

Hx of Colposcopy, LEEP, or Cervical Cryo? YES NO **If yes, which and when?** _____

HPV Vaccination? COMPLETED IN PROCESS NEVER HAD

Sexually active? YES NOT CURRENTLY NEVER **Sexual Orientation:** _____

History of any STDs? YES NO **If yes, which one(s)?** _____

Age at which you first had sex: _____ **Total lifetime partners:** more than 5 less than 5

Current form of birth control? Oral Contraception Condoms None Other_____

Age at menarche (first period): _____

Age at menopause: _____

Postmenopausal hormone replacement therapy use? NEVER CURRENT PAST USE

History of the following? (check all that apply)

[ ]endometriosis [ ] fibroids [ ] infertility [ ] PCOS [ ] urinary incontinence

[ ] ovarian problems, explain_____

[ ] breast problems, explain_____

Menstrual cycle (circle all that apply):

How often are menses? MONTHLY LESS THAN 21 DAYS MORE THAN 35 DAYS IRREGULAR

Describe flow: LIGHT MODERATE HEAVY HEAVY W/ CLOTS

Cramps? YES NO

Prenatal Questionnaire and Information Form

Name:_____ Phone #:_____ Date: _____/_____/_____

Address: _____

Emergency Contact:_____ Relationship:_____ Phone #: _____

Last Grade Completed: _____ Occupation: _____

Insurance Company: _____ Insurance/Medicaid #:_____

How many times have you been pregnant? (Including current, miscarriages & terminations): _____

Date of Delivery	How far along in pregnancy (weeks)	Length of Labor	Birth Weight	Gender	Type of Delivery	Place of Delivery

Were there any complications during these pregnancies or deliveries? If yes, please explain:
(i.e. Gestational Diabetes, Pre-Eclampsia, Pre-Term Labor, Postpartum Depression)

_____

_____

_____

Past Medical History: **Please read carefully**

Diabetes	Yes	No	Rh Sensitization	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Heart Disease	Yes	No	Seasonal Allergies	Yes	No
Autoimmune Disease	Yes	No	Drugs/Latex Allergies	Yes	No
Kidney Disease/UTIs	Yes	No	Breast Issues	Yes	No
Neurologic/Epilepsy	Yes	No	Gyn Surgery	Yes	No
Psychiatric	Yes	No	Operations/Hospitalizations	Yes	No
Hepatitis/Liver Disease	Yes	No	Anesthetic Complications	Yes	No
Varicosities/Phlebitis	Yes	No	History of Abnormal PAP	Yes	No
Thyroid Dysfunction	Yes	No	Uterine Anomalies	Yes	No
Major Accident/Trauma	Yes	No	Infertility	Yes	No
History of Blood Transfusions	Yes	No	Do you use a vape?	Yes	No
Do you drink alcohol?	Yes	No	Do you smoke tobacco?	Yes	No
Do you use street drugs?	Yes	No	If yes, how much & how long?		

If yes to anything above, please explain: _____

Possible Infection Screening (**Past and/or Present**)

IV Drug Use	Yes	No	Work in High Risk Field (Nursing, etc.)	Yes	No
Exposure to Tuberculosis	Yes	No			
Have you or a partner been infected with:					
Gonorrhea	Yes	No	Hepatitis B or C	Yes	No
Chlamydia	Yes	No	Genital Herpes	Yes	No
Syphilis	Yes	No	HPV	Yes	No

Genetic Screening (**Please read carefully**)

Are you over the age of 35?	Yes	No	Muscular Dystrophy?	Yes	No
Haitian or Mediterranean Descent?	Yes	No	Cystic Fibrosis?	Yes	No
Asian Descent?	Yes	No	Huntington's Chorea	Yes	No
Have you or any family member had:			Intellectual Disability? (i.e. Autism)	Yes	No
Any neural tube defects?	Yes	No	If so, was person tested for "Fragile X"	Yes	No
Down's syndrome?	Yes	No	Other genetic or inherited disorders?	Yes	No
Congenital heart defect?	Yes	No	Maternal Metabolic Disorder (EG, Type 1 Diabetes, PKU)	Yes	No
Are you Jewish?	Yes	No			
Family history of Tay Sachs?	Yes	No	Have you or the baby's father had a child with birth defects not listed above?	Yes	No
Sickle Cell Disease or Trait?	Yes	No			
Hemophilia or Other Blood Disorders?	Yes	No			

If yes to anything above, please explain: _____

_____

_____

Have you had more than 3 abortions? _____ Have you had more than 3 miscarriages? _____

Have you ever used Marijuana, Cocaine, or other street drugs? _____

If yes, what? _____

Do you medicate yourself with an herbs or non-traditional medications?_____

If yes, what? _____

In this pregnancy so far, have you had:

Any bleeding? _____ Any odor? _____

Any fever? _____ Headaches?_____

Abdominal pain? _____ Urinary Complications?_____

What was the first day of your last period? _____/_____/_____ **UNKNOWN**

Are you **definite** or **approximate** about your last period date? **(CIRCLE ONE)**

WORKING DURING PREGNANCY

The great majority of expectant mothers can continue to work until late in pregnancy without any problem. Sometimes, however, the physical changes entailed in pregnancy or the demands of a woman's job can create workplace difficulties. Please let us know if you have any concerns in this regard. We usually are able to suggest simple steps to deal with the fatigue, "morning sickness," or aches and pains that can be particularly challenging while you are at work. If you have more serious symptoms or concerns about potential workplace hazards to you or your baby, we will evaluate and respond accordingly.

When medically appropriate we will recommend that a pregnant patient be placed on disability leave from her job. Such leave is rarely required, however, and in the absence of a serious condition that would endanger the health of the mother or baby, medical ethics prevent it from making such a recommendation. We will, however, do everything we can to reduce or eliminate pregnancy-related difficulties you may be having at work. This includes contacting your employer, when appropriate, to recommend helpful adjustments or alterations to your duties.

Again, please tell us of any work-related concerns you may have.

_____ _____

Signature **Date**

VIDEOTAPING

In order to limit distractions and provide optimal care during the delivery of your baby, it is the policy of Baby Steps to prohibit videotaping during deliveries. If you have any questions or concerns, please bring these to our attention. By signing below, you acknowledge you have been informed of and agree to abide by this policy.

_____ _____

Signature **Date**

CONSENT FOR VAGINAL DELIVERY OR CESAREAN SECTION

To the Patient: You have the right as a patient to be informed about your condition and the recommended medical, surgical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I (We) voluntarily request Dr._____ as my physician, and such associates, technical assistants, and other health care providers as they deem necessary to treat my condition which has been explained to me as:

PREGNANCY

I (We) understand that the following medical, surgical, or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these PROCEDURES:

VAGINAL DELIVERY OR CESAREAN SECTION

I (We) consent to the disposal by hospital authorities of any tissues, organs, or amputations which may be removed.

I (We) understand that my physician may discover other or different conditions which require different or additional procedures than those planned. I (We) authorize the physician and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (We) _____ do _____ do not consent to the use of blood or blood products as deemed necessary.

I (We) understand that treatment of my medical condition may require transfusions of blood, blood components or derivatives, and I (we) voluntarily consent and authorize such transfusions. It is my (our) understanding that this consent to transfusion applies to this operation and this hospital stay only.

I (We) understand that there are risks and hazards to transfusion, however unlikely, including, but not limited to the following:

1. Allergic reactions, including hives and itching;
2. Fever, sometimes accompanied by chills;
3. Heart failure;
4. Infection by bacteria, parasites or viruses, including malaria, hepatitis and AIDS;
5. The possibility of blood incompatibility, which can result in severe complications, including kidney failure and, rarely, death.

I (We) have been given an opportunity to ask questions, and my physician has explained possible alternative forms of treatment, the risk of refusing transfusions, the procedures to be used, and the hazards involved.

I (We) understand that no warranty or guarantee has been given to me as a result.

Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (We) realize that common to surgical, medical, or diagnostic procedures is the potential for infection, blood clots in veins or legs and lungs, hemorrhage, allergic reactions, nerve damage causing numbness and/or pain to lower extremities, and even death.

I (We) also realize that the following risks and hazards may occur in connection with this particular procedure:

IF VAGINAL DELIVERY:

1. Injury to bladder and/or rectum, including a hole (fistula) between bladder and vagina and/or rectum and vagina.
2. Hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control.
3. Sterility.
4. Brain damage; injury or even death occurring to the fetus before or during labor and/or vaginal delivery whether or not the cause is known.
5. Risks of anesthesia.
6. Extension of incision or laceration of vagina, cervix, uterus or rectum.

IF CESAREAN SECTION:

1. Injury to bowel or bladder, including a hole (fistula) between bladder and vagina.
2. Injury to tube (ureter) between kidney and bladder.
3. Brain damage; injury or even death occurring to the fetus before or during labor and/or cesarean section whether or not the cause is known.
4. Uterine disease requiring hysterectomy.
5. Sterility.
6. Hemorrhage possibly requiring blood administration, hysterectomy, and/or artery ligation to control.
7. Risks of anesthesia.
8. Extension of incision or laceration of uterus, cervix, or vagina.

I (We) understand that anesthesia involves additional risks, but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures.
I (We) realize the anesthesia may have to be changed without explanation to me (us).

I (We) understand that certain complications may result from the use of any anesthetic, including respiratory problems, paralysis, drug reaction and even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury of vocal cords, teeth or eyes. I (We) understand that other risks or hazards resulting from spinal or epidural anesthetics include headaches and chronic pain.

I (We) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatments, risks of non-treatment, the procedures to be used, and the risks and hazards involved. This includes the understanding that all DNR (Do Not Resuscitate) orders or advanced directives are suspended while in the operating suite unless special circumstances are discussed prior to surgery on an individual case basis by the surgeon, anesthesiologist and patient or legal next of kin. I (We) believe that I (we) have sufficient information to give this informed consent.

In compliance with the Safe Medical Device Act of 1990, if an FDA designated medical device is implanted during surgery, I understand that my Social Security Number and name will be released to the manufacturer.

I (We) certify that this form has been fully explained to me that I (we) have read it or have had it read to me; that the blank spaces have been filled in, and that I (we) understand its contents.

I authorize the staff of AdventHealth Daytona Beach to take still photographs, motion pictures, television transmissions, and/or videotaped recordings, provided my identity is not revealed by the pictures or by descriptive text accompanying them.

_____
Date

_____
Signature of Patient

_____
Witness

_____
Signature of Physician Obtaining Consent

_____
Interpreter (if applicable)