

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.

X _____
PATIENT OR PARENT (if a minor)

AND/OR

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

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

☐ **Declined to provide**

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:

PATIENT NAME: _____

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: _____

PATIENT NAME: _____

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

PATIENT NAME: _____



Prenatal Questionnaire and Information Form

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

Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

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: _____

PATIENT NAME: _____

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	Have you or the baby's father had a child with birth defects not listed above?	Yes	No
Family history of Tay Sachs?	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)

PATIENT NAME: _____



Mental Health History

5P's Prenatal Substance Use Screen

Did any of your Parents have problems with alcohol or drug use? Friends (peers)?

___ Yes ___ No

___ Yes ___ No

Partner?

___ Yes ___ No

Before you were pregnant did you have problems with alcohol or drug use? (Past)

___ Yes ___ No

In the past month, did you drink beer, wine or liquor, or use other drugs? (In pregnancy)

___ Yes ___ No

Substance Use History

What substances are you currently using or have you used in the past?

Tobacco/vape ___ Current ___ Past ___ Never

Marijuana ___ Current ___ Past ___ Never

Cocaine ___ Current ___ Past ___ Never

Methamphetamine ___ Current ___ Past ___ Never

Opiates ___ Current ___ Past ___ Never

Fentanyl ___ Current ___ Past ___ Never

Other _____ ___ Current ___ Past ___ Never

Do you have a history of medication assisted therapy (MAT)? ___ Yes ___ No

Do you have a history of outpatient substance use disorder treatment? ___ Yes ___ No

Do you have a history of inpatient substance use disorder treatment? ___ Yes ___ No

Any hospital stays or ER visits related to substance use? ___ Yes ___ No

(toxicity/overdose, septic arthritis, endocarditis, heart/lung disease, hepatitis, etc.)

Mental Health History

Do you feel like you struggle or have struggled with

Depression ___ Yes ___ No Anxiety ___ Yes ___ No

Bipolar Disorder ___ Yes ___ No PTSD ___ Yes ___ No

ADHD ___ Yes ___ No Other (list) _____

Have you ever been diagnosed with

Depression ___ Yes ___ No Anxiety ___ Yes ___ No

Bipolar Disorder ___ Yes ___ No PTSD ___ Yes ___ No

ADHD ___ Yes ___ No Other (list) _____

Have you ever taken medication for a mental health disorder? ___ Yes ___ No

Have you ever received counseling for a mental health disorder before? ___ Yes ___ No

Have you ever been to the ER for a mental health concern before? ___ Yes ___ No

Have you ever been hospitalized for a mental health concern before? ___ Yes ___ No

Do you feel like you have struggled to receive consistent mental health treatment? ___ Yes ___ No

Reason



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 Party



Consent for Gynecological Examination

Florida Status Section 456.51 (Consent for Pelvic Examination) requires the written consent of a patient or a patient's legal representative before a healthcare practitioner, a medical student, or other student receiving training as a healthcare practitioner may perform a pelvic examination on a patient.

By signing below, I consent to a pelvic examination that my health care provider believes is medically necessary and appropriate. This examination refers to any combination of techniques, which may include, but not be limited to, the use of the health care provider's gloved hand or instrumentation to examine the external genitalia, vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs.

I have been given the opportunity to ask questions about the examination, or procedure associated with such examination, and I have been informed of the risks associated with the same. This consent confirms that I have agreed to proceed with the pelvic examination, and related procedure, willingly and without objection.

I have read and fully understand the above statements and the explanations. This consent was given freely and voluntarily.

Patient/Responsible Party Signature

Date



IMPORTANT INFORMATION REGARDING BILLING:

Our providers are here to provide you with the best medical care. Their primary concern is with your health and well-being, not with your insurance status or the company you may be insured with. As we attempt to work with all pregnancy medicaid plans and numerous insurance companies, there are some that continue to decline us as providers.

- If you are covered under an insurance plan that we are unable to accept at Baby Steps, but are choosing to come to this clinic for care over a provider in network with your insurance, you will be asked to pay our self-pay rates.

- If you are without insurance at the time of your appointment, we will ask for a \$60 payment at the beginning of each visit, \$120 for a visit with an ultrasound.

- If you are covered under a private insurance that is accepted at this clinic, a copayment may be required at the start of each visit. This copayment is calculated through your insurance company and it is a requirement for us to charge the calculated amount at each visit by your insurance company.

Baby Steps is unable to bill insurance companies for global pregnancy and functions as a specialist doctors office. If your insurance states they cover pregnancy completely, but we are collecting a copay, this is likely why. We apologize for the inconvenience but we are required by law to charge your specialist copayment each visit. If you have questions or need to set up individualized payment plans, you can speak with our billing and insurance manager. Please do not cancel your appointments due to inability to pay a copay. We will always work with patients as much as possible to ensure mother and baby get the care they need.

Additionally, all labs and cultures will be sent to Quest Diagnostics. If you are without insurance, labs will be ordered using the Uninsured Patient Pricing that Quest offers.

I have read the above and understand I am responsible for knowing the current billing policy of Baby Steps Daytona.

Patient's Signature

Date



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Dr. Pamela Carbiener and Staff** 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 *Jaqueline Butler, Practice Manager, 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 Confidential."

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 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



Consent to Share De-Identified Information

At Baby Steps, we are committed to protecting your privacy while also working to improve healthcare through research and education. Sometimes, we collaborate with universities and research partners to study ways to improve prenatal and postpartum care in our community.

We may share de-identified information from your medical record. *De-identified* means that your name, address, date of birth, phone number, and any other details that could directly identify you will be removed before any information is shared.

- Your participation in care at Baby Steps will not be affected by this consent.
- You will not be personally identified in any reports or publications.
- You may revoke (take back) this consent at any time by notifying Baby Steps in writing.
- If you do not sign this consent, your care at Baby Steps will not be affected in any way.

By signing below, you agree that Baby Steps may share your de-identified medical information with universities and research partners for the purposes of education, research, and improving healthcare services.

Patient Name: _____

Signature: _____

Date: _____



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. Signing below confirms you have read the above statement.

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



Policy for Circumcision

This is not a consent or agreement for the procedure.

This is just acknowledging our policy and must be signed.

The circumcision is an elective procedure offered by our doctor to be performed after delivery of a baby boy. If you know that you are having a boy, or you wish to not know the gender prior to delivery but still wish to pay for a circumcision on the chance that you do deliver a boy, you may discuss with our check in staff starting the payment process towards this procedure.

The fee for the circumcision procedure is \$350. We accept cash or credit card payments only and the fee must be paid **prior to the circumcision procedure**. This fee can be paid all at once or in parts, as long as it is completed **prior to the circumcision being done**. Circumcisions must be done within **four (4) weeks from delivery**. If a payment plan needs to be set up, the full amount must be collected before your baby's circumcision will be done.

If you pay for a circumcision and then elect not to have the procedure done or have a baby girl and the procedure is no longer needed, all money paid towards said procedure will be refunded to you.

This is an elective procedure; we will not submit charges to your insurance company.

By signing below, you are **only** acknowledging that you have been informed of our new circumcision policy. **Again, this is not a consent for the procedure or an agreement to its performance**. If you decide to have your baby circumcised, we will provide you with separate paperwork.

Patient Signature

Date



**Notice to Obstetric Patients
(See section 766.302(7), Florida Statutes)**

I have been furnished information by Baby Steps Daytona, prepared by the Florida Birth Related Neurological Injury Compensation Association, and have been advised that: Pamela Carbiener, MD., and participating medical providers in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery, or resuscitation. For specifics on the program I understand I can contact the Florida Birth Related Neurological Injury Compensation Association (NICA), Post Office Box 14567 Tallahassee, FL 32317-4567, telephone (850) 488-8191, toll free 1-800-398-2129.

I further acknowledge that I have received a copy of the brochure prepared by NICA

Dated this _____ day of _____, _____

Signature of Patient

Name of Patient

Social Security Number

Nurse or Physician

Witness



Consent for the AIDS Antibody Blood Test

I, _____, am a patient of Baby Steps Daytona. The providers have informed me that they recommend I receive a blood test for HIV in order to facilitate my treatment and protect hospital personnel and other patients.

I have been informed that my blood will be tested in order to detect whether or not I have antibodies in my blood to the HTLV-III, which is the probable causative agent for Acquired Immune Deficiency Syndrome (AIDS). I understand this test is performed by drawing blood and using a chemical substance to test the blood.

I have been informed the HIV screening may initially be inconclusive and require additional tests. I understand that rarely the test will be negative with recent exposure.

I understand that the blood test becomes part of my confidential medical record.

Subject to the foregoing, the hospital, to the best of its ability, will not disclose the results of these tests to others except to the extent such disclosure is required in order to safeguard the well-being of patients and employees at the hospital or other persons at risk.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results, and have had all my questions answered. Furthermore, I acknowledge that I have given consent for performance of the blood test to detect antibodies to the HTLV-III virus.

Patient Signature

Date

Witness