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

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_____

PATIENT NAME:_____

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: _____

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			
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)**

PATIENT NAME:_____

Mental Health History

5P's Prenatal Substance Use Screen

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

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. 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

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. **Pamela Carbiener** 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).

Consent for Vaginal Delivery or Cesarean Section
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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 and of Halifax Daytona 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)