COLUMBUS WOMEN'S HEALTH ORGANIZATION, P.C.
3850 ROSEMONT DRIVE
COLUMBUS, GA
706-323-8363

PATIENT PRIVACY NOTICE

In accordance with the Federal Privacy law (HIPPA)t Columbus Women's Health Organization, P.C. keeps medical information and records confidential and will only use them for patient treatment, health care operations, and billing purposes.

TREATMENT: Our physicians: clinicians, and staff will use your medical information to give you the best possible care.

HEALTH CARE OPERATION: Columbus Women's Health Organization, P.C. will use this information for appropriate follow-up care, patient notification: statistical & regulatory requirements, and internal quality assurance programs.

DISCLOSURE OF INFORMATION WITH EXTENUATING CIRCUMSTANCES.

1. Health information will be given to family members in case of an emergency or under other circumstances with proper authorization and documentation.
2. Health information may be given to other physicians or institutions under emergency situations.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.
5. I understand and agree to the above Privacy Policy

Patient Signature Date

Patient Name - Printed Witness

3850 Rosemont Drive, Columbus, GA 706-323-8363

I, _____ am 18 years of age or older.
(Name)

PARENTAL CONSENT

I understand that state law requires my consent in order for _____ to have an abortion because she is less than 18 years of age. I hereby give my consent as **parent** or **legal guardian**. (CIRCLE)

_____

Signature of Parent / Legal Guardian

I have been informed that state law requires unemancipated minors to have the consent of a parent or legal guardian before having an abortion. I verify that the signature of _____ is authentic written consent for my abortion signed by my **parent** or **legal guardian**. (CIRCLE)

_____

Signature of Minor

EMANCIPATED MINOR

I have been informed that state law requires unemancipated minors to have the legal consent of a parent or legal guardian. I am now legally freed from the care, custody and control of my parent or legal guardian. **Circle One:** marriage license | divorce decree | court order

_____

Signature of Emancipated Minor
I have examined document(s) provided and made appropriate copies of such.

_____ _____

Signature of Clinic Representative Date

CONTRACEPTIVE METHOD

I hereby request that hormonal contraceptives (pills or patches) be prescribed information in the 'Patient Guide' regarding hormonal contraceptives. I Understand that there are risks of minor and major complications which may occur with oral or transdermal contraceptive use. I have fully disclosed my past and present medical histories including allergies, blood conditions, past and present disorders and prior medications taken. I have never had thrombophlebitis disorders (clots in veins), coronary artery disease or a malignancy of the cervix, breast or another reproductive organ. I am not hypertensive (high blood pressure), diabetic, nor do I have sickle cell anemia. When available, one cycle of hormones (one pack of twenty-one pills or three patches) will be given to me at no additional charge, as well as a prescription for 5 more packs of pills and / or patches,

_____ _____

Patient Legal Signature Date

Columbus Women's Health Organization, P.C
3850 Rosemont Dr., Columbus, GA
706-323-8363

Office Use:

Financial

Patient Number: _____

PLEASE PRINT
(All information is confidential)
Initial Errors

Name_____

Age _____ Date of Birth _____

Address _____

City _____

County _____

State _____ Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Is patient married? _____ Yes _____ No

Last School Year Completed: (CIRCLE)

Elem & High: 1 2 3 4 5 6 7 8 9 10 11 12

College / Tech: 1 2 3 4 5 6 7 8

Race/Specify: American Indian ☐ Black ☐ White ☐

Asian ☐ Hispanic Origin / Specify: _____

Other: _____

How did you find out about our clinic? (CIRCLE)

Family ☐ Friend ☐ Google Search ☐

Abortion Clinics Online directory ☐

Other / Specify: _____

Please initial ONE of the following:

I have been advised that I should not drive myself home after the procedure. I have arranged for a ride home. _____

I have been advised that I should not drive myself home after the procedure. Since I am NOT complying with this recommendation, I hereby release this Center of any responsibility during that period of travel. _____

FINANCIAL / PERSONAL RESPONSIBILITY AGREEMENT

In some cases, the physician may require additional testing for patients to verify a very early pregnancy, or for a complication of pregnancy. The additional medical attention and services cannot be anticipated prior to your visit to the clinic.

Should you need further testing or services. you will receive bills for services. Depending on where your services were rendered these bills may be from lab for blood work or from physician or local hospital. Again, these charges are your responsibility and are not part of the fees charged by this facility.

As a patient at this facility, I understand that I am responsible for the medical costs of any additional service or testing.

Initial _____

Columbus Women's Health Organization, P.C. operates us an outpatient clinic, and as such, will not be held responsible for any items. money, or valuables damaged, lost, or stolen during my stay.

Initial _____

I have been given the opportunity to view the ultrasound if I so choose to do so. My decision is indicated / checked below.

I choose to view the ultrasound _____

I decline to view the ultrasound _____

I choose to listen to the fetal heart tones _____

I decline to listen to the fetal heart tones _____

The patient must waive the right to treatment for gonorrhea at this time, or the procedure shall not be performed. I waive the right to treatment for gonorrhea.

Initial _____

Patient Signature _____

Date _____

COUNSELING INFORMATION

Please answer the following questions to enable us to help you more fully.

ALL INFORMATION IS CONFIDENTIAL.

1. Who have you talked with about your decision to have an abortion? If they agree with your decision, check agree. If against your decision, check disagree. **If you didn't talk with them, leave blank.**

AGREE	DISAGREE	NAME	AGREE	DISAGREE	NAME
_____	_____	Physician _____	_____	_____	Counselor _____
_____	_____	Mother _____	_____	_____	Friend _____
_____	_____	Father _____	_____	_____	Boyfriend _____
_____	_____	Sister _____	_____	_____	Husband _____
_____	_____	Brother _____	_____	_____	Other(s) _____

YES | NO

2. ____ ____ Do you feel that this is your decision to have an abortion? If you answer NO, please explain who is forcing you to have an abortion. _____

3. ____ ____ Do you think having this abortion is in your best interest?

4. ____ ____ Are you sure you want to have an abortion?

5. ____ ____ Do you think you will most likely be able 10 go on with your normal activities without emotional or psychological problems because of the abortion?

6. ____ ____ Who is here with you today? Name(s):_____

____ ____ Does this person(s) know that you are having an abortion?

7. ____ ____ Who is driving you home? Name(s):_____

Please give their phone number if they are coming to pick you up.

Phone number: _____

____ ____ Does person(s) know that you are having an abortion?

---

8. Why do you want to have the abortion? _____

---

9. What are you most concerned about today? _____

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10. How can we leave a message for you or contact you in case of all emergency?

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11. Who can we give instructions to about your postoperative care? _____

_____ _____

Patient's Signature Date

COLUMBUS WOMEN'S HEALTH ORGANIZATION, P.C.

Patient Information Verified in medical intake by: _____

I certify that the information in the medical chart is correct and I understand that Columbus Women's Health Organization, P.C. has relied upon this information. In the continuation of care, I understand Columbus Women's Health Organization. P.C. will be calling to check on me and this is the telephone number that can be used. _____ **Pt. Initials** _____

TO THE PATIENT: It is very important that you fill in this COMPLETELY AND ACCURATELY, INCLUDING ADDRESS, PHONE NUMBER, DATES, ETC. Your treatment here depends on this, and we need a complete and accurate medical history in order to give you proper care. ALL OUR RECORDS ARE CONFIDENTIAL!

PREGNANCY HISTORY

_____ Total number of previous pregnancies
_____ Number of full-term pregnancies
_____ Number of premature deliveries
_____ Number of living children

Dates of deliveries _____
_____ Number of miscarriages
_____ Number of abortions
_____ Date of last abortion

Complications with pregnancies, deliveries miscarriages, or abortions: (Explain) _____

YES | NO

_____ _____ Pelvic examination. If so, when (most recent)?
_____ _____ Have you ever had Pap Smear? Date of last one _____ Normal ( ) Abnormal ( )
_____ _____ History of abnormal Pap Smears? If so, what class and how was it treated?
_____ _____ Vaginal infection (yeast, etc. or STD (Sexually Transmitted Disease; Chlamydia, Herpes, HIV, Vaginal warts, Trichomonas, Gonorrhea, Syphilis. etc.) When? _____
_____ _____ PID (Pelvic Inflammatory Disease) or infection of (he uterus or fallopian tubes? When?
_____ _____ Discharge from your vagina now? If so, color ___ odor ___ itching ___
_____ _____ Cancer or the uterus, cervix, or vagina
_____ _____ Breast mass, lumps, discharge or breast cancer?
_____ _____ Breast feeding now?

MEDICAL HISTORY - Check if you have ever had any the following:

YES | NO

_____ _____ ALLERGY or PROBLEMS with drugs (example: Penicillin, Tetracycline, Antibiotics, Novocaine, Lidocaine, Aspirin, Iodine, Betadine, X-ray dye, Valium, Librium. Tranquilizers. Codeine, pain killers, other)? If yes, what drug? _____
_____ _____ ALLERGY to fish or shellfish, avocados, water chestnuts, any other foods or latex or condoms. Please list: _____
_____ _____ Taking medications/drugs now? If yes, what?
_____ _____ Have you taken any Xanax, Valium, Librium, Centrax, Halcyon, Ativan, or other tranquilizers or sleeping pills in the last six months? When?
_____ _____ Smoke cigarettes? _____ Packs/day _____ For how long?
_____ _____ Drink Alcohol? _____ How much/day _____ For long?
_____ _____ 1. Have you been hospitalized? Please give date / reason _____
_____ _____ 2. Have you had any outpatient surgeries (example: D&C, cervical cautery, laser surgery etc.)? Please give date/reason _____
_____ _____ 3. Have you ever gotten a blood transfusion? Please give date/reason _____

Check if you have now or have ever had any of the following:

YES | NO		YES | NO		YES | NO	
_____ _____	Heart Murmur	_____ _____	Cancer	_____ _____	High Blood Pressure
_____ _____	Mitral Valve Prolapse	_____ _____	Liver Disease	_____ _____	Sickle Cell Anemia
_____ _____	Heart Disease	_____ _____	Hepatitis	_____ _____	Sickle Cell Trait
_____ _____	Rheumatic Fever	_____ _____	Varicose Veins	_____ _____	Thyroid Disease
_____ _____	Are you RH Negative	_____ _____	Phlebitis (infected veins)	_____ _____	Gallbladder Disease
_____ _____	"Cold or Flu" now	_____ _____	Migraine Headaches	_____ _____	Psychiatric Care
_____ _____	Pneumonia	_____ _____	Epilepsy	_____ _____	Drug addiction or Abuse
_____ _____	Tuberculosis	_____ _____	Seizure Disorder	_____ _____	Problems with Anesthesia

Is there any other medical information? _____

I have fully completed told my past and present medical history, including prior surgery. allergies, blood conditions, present/prior medications and drugs taken, and reactions I have had no anesthetics, medicines, or drugs. I have read and fully understand the PATIEN MEDICAL HISTORY & DISCLOSURE. The information provided therein is complete and accurate.

Patient Signature: _____ Date: _____

CONSENT TO ABORTION

I, _____, age_____ , do hereby give my consent to, and request and authorize

Dr. _____ and assistants of his/her choosing to perform an ABORTION on me. I warrant that the first day

of my last normal period was _____ (date).

Patient's Initials		Counselor Initials
☐	**ALTERNATIVES:** The initial alternative to ending a pregnancy is to continue it to term and birth. Therefore, one usually either takes on the duties of parenthood, or arranges for adoption, Continued pregnancy has medical and mental risks, considered by most medical specialists to be greater than the risks associated with abortion. Parenthood has both benefits and risks that vary widely depending upon tilt; individual and her unique circumstances. The risks, benefits, and detriments of continued pregnancy in your situation should be carefully considered before deciding upon an abortion	☐
☐	**PURPOSE OF ABORTION:** I have been advised and have had explained to me what a Vacuum Aspiration/Dilation and Evacuation abortion is and what it is for. I understand that tests and/or examinations performed on me indicate that I ant pregnant and that the purpose of the abortion is to terminate my pregnancy. know that I have the right to continue this pregnancy to its full term but it is my personal choice to end it now. Al of my questions have been answered.	☐
☐	**RISKS:** Abortion is surgery, and like all surgery has certain statistical risks of both minor and major complications including the possibility of death. Please read carefully so that you understand We cannot make any guarantees or assurances that the result obtained from an abortion procedure will always be perfect. Any time someone undergoes medical treatment, there is always the possibility of an unusual complication that may not be foreseen and is not specifically mentioned in this consent form.	☐
☐	**ANESTHESIA:** I understand that with any drug or medication there are potential risks and complications including, but not limited to, listed here. I further understand that IV medications generally carry more potential risks than local anesthetics. I understand the risks, of LOCAL anesthesia range from minor to severe, including convulsions, cardiac arrest, and possibly the rare event of death. I understand the risks of IV anesthetics range from minor to severe including nausea, phlebitis. cardiac arrest, respiratory failure, prolonged unconsciousness, and even death. L further understand that if I choose to receive IV anesthesia, it may interfere with my ability to concentrate and impair operation of machinery or motor vehicles. I acknowledge that with IV medications I have been advised not to drive or operate machinery for at least 24 hours (or longer if full alertness has not returned), and understand that I would be endangering myself and others by driving or operating machinery during that time period, I hereby consent to the administration of anesthesia und authorize the use of such anesthetics as the doctor or his/her assistants deem advisable with the exception of I request anesthesia. I warrant that I have NOT had anything at all to eat or drink for at least six hours before my appointment with the exception of _____.	☐
☐	I understand that having an abortion involves some risks to me, including but not limited to the following: **DEATH; HEMORRHAGE; SHOCK; CARDIAC ARREST; PERFORATION (puncture) of the uterus and INFECTION.** In order to help avoid infection as a possible complication, I understand I am responsible for taking the precautions explained to me and listed in the post-operative instructions will receive. In some instances all pregnancy may not he removed and an INCOMPLETE ABORTION may occur. If the abortion is incomplete, I may have a fever, heavy bleeding and/or cramping. If any of these symptoms appear, I should immediately contact Columbus Women's Health Organization, or go to a hospital or see a doctor at once. I understand that the procedure may have to be repeated because of retained tissue or other problems. I understand that the doctor, clinic, and hospital make no guarantees regarding the ab0Ltion and that I may still be pregnant after the abortion. I understand that infection or other complications might require a D&C procedure (cleaning of the uterus), a hysterectomy or may result in death. I understand that if I have a multiple pregnancy, the chance of complications is increased. I understand CERVICAL INCOMPETENCY, which means that I may have problems maintaining a pregnancy in the future resulting possible miscarriage, stillbirth, low birth weight, and premature delivery is a risk associated with any pregnancy. EMOTIONAL DISTRESS, such as depression or other psychological consequences may occur. I understand I may call the clinic for follow-up counseling and referral. I accept all these risks and take responsibility for their consequences.	☐

ECTOPIC PREGNANCY: (pregnancy in the tubes) - I understand that in some instances the pregnancy can be in the fallopian tubes leading to the uterus. I understand that an ectopic pregnancy can be difficult to detect and that an abortion procedure cannot terminate such a pregnancy, A tubal pregnancy occurs when the fertilized egg implants in the fallopian tube instead of the uterus. If this condition is not stopped, the fetus develops in the tube until it is large enough to burst the tube. Although the chances of a tubal pregnancy are small, the risk of death from a ruptured tubal pregnancy is very great. For this reason, tubal pregnancies must be surgically removed and require hospitalization. This is a preexisting medical condition for which Columbus Women's Health Organization, its staff and physicians, assume no medical or financial responsibility.

LABORATORY: E consent to the disposal of any tissue or other contents of my uterus, which may be removed during the abortion. I also consent to the administration of Rhogam (or equivalent) should my blood be Rh I understand that the doctor or clinic may need to contact my emergency contact or myself regarding additional laboratory findings and consent thereto.

ADDITIONAL PROCEDURES: If during the course of the abortion procedure any unforeseen conditions or complications arise, and the. doctor in his/her professional judgement decides that different or additional procedures including but not limiting to anesthesia or blood transfusion or the association of another doctor, or hospitalization are necessary, I give my consent as such. I assume all responsibilities for payment for any additional services set forth above. I give permission for my parents (or legal guardian where applicable) or other person (name set forth below) to be notified by the doctor or staff of the clinic. The correct identity, address, and phone numbers of my emergency contact are set for below.

EMERGENCY: I have been given an emergency telephone number which I can call 24 hours a day for assistance, I agree to notify the clinic in the event of a problem. My failure to give notice within 72 hours releases the doctor and the clinic from any responsibility to me for emergency care.

FOLLOW UP: I have been advised to return to my doctor or Columbus Women's Health Organization within 3-4 weeks for a follow up examination. I understand that I should have this examination in order to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process has gone properly. My failure to obtain follow up care relieves the Doctor and Clinic of any further responsibility to me.

I have read and fully understand this form. All blanks have been fined in before I signed my name. All information given herein and my Medical History is true and correct and I realize that the Doctor and Columbus Women's Health Organization have relied on such information. My consent has been freely given. I have rejected the alternatives to abortion and this procedure is being performed at my request.

Patient Information

Patient Signature: _____

Date: _____

Address: _____

City, State, Zip: _____

Patient Home Phone: _____

Patient Work Phone: _____

Patient Signature: _____

Emergency Contact Information

Person to Notify: _____

Their Address: _____

City, State, Zip: _____

Phone: _____

Counselor: _____