Adebayo J. Adesiomo, M.D.,F.A.C.O.G., P.A.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature_____ Date:_____

CERTIFICATION

Each item on this certification form must be reviewed. The woman should place her initials beside each statement and sign the bottom of the form.

I certify that the following information was presented to me, at least 24 hours prior to the abortion by the physician who is to perform the abortion or by the referring physician:

_____the name of the physician who will perform the abortion;
_____the particular medical risks associated with the particular abortion procedure to be employed; including when medically accurate:
- _____ the risk of infection and hemorrhage;
- _____ the potential danger to subsequent pregnancy and of infertility; and
- _____ the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer.

_____the probable gestational age of the unborn child at the time the abortion is being performed; and

_____the medical risks associated with carrying the child to full term.

The physician who is to perform the abortion or the physician's agent has informed me that:

_____medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

_____the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion;

_____public and private agencies provide pregnancy prevention counseling and medical referrals for obtaining pregnancy prevention medications or devices; and

I have also been informed that:

_____I have the right to review the printed materials prepared by the Texas Department of Health entitled the "A Woman's Right to know " booklet and the resource directory, which describe the unborn child and list agencies that offer alternatives to abortion, and that those materials must be given to me if I choose to view them;

_____"A Woman's Right to Know" booklet and resource directory are also accessible on an Internet website sponsored by the department.

I made the following choice (choose one of the following):

_____I requested and was provided a printed copy of "A Woman's Right to Know" booklet and the resource directory.

_____I chose to review the "Woman's Right to Know" materials on this website.

_____I declined the informational materials.

_____

Signature Date

_____

Printed Name

SUBURBAN WOMEN'S CLINIC

HEALTH HISTORY

Date_____

Name_____Date of Birth_____Age _____

Phone_____Address_____City_____State_____

Zip_____

Race _____ Marital Status _____County_____

Health Insurance_____

First day of last normal menstrual period_____Height_____Weight_____

Full Term Pregnancies_____# Abortions_____# miscarriages_____

Allergies to Medication_____

Please check any that apply: Emotional Problems_____; Female Problems_____; Diabetes_____;

Seizures_____; Heart Trouble_____; V.D._____; Blood Clots/Bleeding_____;

Kidney Problems_____; Previous Surgery_____ Anemia_____;

Have you ever had a pelvic exam? _____ Is there anything you would like to discuss Privately?_____

LEGAL OR ILLEGAL DRUGS TAKEN IN THE LAST 24 HOURS: _____

HOW DID YOU HEAR ABOUT THE CLINIC? (Check all that apply)

_____friend/family referral

_____previous patient

_____yellow pages

_____website/internet

_____doctor referral (please list name and location)_____

_____other_____

SUBURBAN WOMEN'S CLINIC
3101 RICHMOND #250 HOUSTON, TX 77098
(713)526-6500

PATIENT AGREEMENT RU486/ MIFEPREX

1. I have read the Medication guide for using Mifeprex and misoprostol to end my pregnancy.
2. I have discussed the information with my health care provider and my questions have been answered.
3. I am aware of the risks and benefits of this procedure.
4. I believe I am no more than 49 days pregnant
5. I understand that I will take Mifeprex in my provider's office
6. I understand that I will take misoprostol at home after I take Mifeprex.
7. My provider gave me advice on what to do if I develop heavy bleeding or need emergency care due to the treatment.
8. Bleeding and cramping do not mean that my pregnancy has ended. Therefore, I must return to my provider's office in about a week after taking the Mifeprex to be sure my pregnancy has ended.
9. I know that in some cases, this treatment will not work. This happens in about 5 to 8 women out of 100 who use this treatment.
10. I understand that if this does not end my pregnancy, there is a chance of birth defects due to the medication I took. I will talk with my provider about my choices, which may include a surgical procedure to end my pregnancy.
11. I understand that if these medications do not end my pregnancy and I decide to have a surgical procedure or if I need a surgical procedure to stop bleeding, my provider will do the procedure or refer me to another provider.
12. I understand that care provided in my provider's office will be covered by the fee I have paid. However, if I require treatment or surgery in a hospital or any other setting outside of my provider's office, it will be at my expense.
13. I have my provider's name, address and phone number to call if I have any questions. I know that the phones are answered 24 hours a day by a nurse on call (or the doctor).
14. I have decided to take Mifeprex and will follow my provider's instructions.
15. I will return to the office in about one week for follow up and after that according to my provider's instructions.

Patient Signature:_____ Date:_____

Patient Name (print):_____

Provider's Signature: _____ Date:_____

Name of Provider (print): Adebayo J. Adesomo, M.D.

GIVE COPY TO PATIENT- KEEP ORIGINAL IN CHART

MIFEPREX® (Mifepristone) Tablets, 200 mg

PATIENT AGREEMENT

Mifeprex* (mifepristone) Tablets

1. I have read the attached MEDICATION GUIDE for using Mifeprex and misoprostol to end my pregnancy.
2. I discussed the information with my health care provider (provider).
3. My provider answered all my questions and told me about the risks and benefits of using Mifeprex and misoprostol to end my pregnancy.
4. I believe I am no more than 49 days (7 weeks) pregnant.
5. I understand that I will take Mifeprex in my provider's office (Day 1).
6. I understand that I will take misoprostol in my provider's office two days after I take Mifeprex (Day 3).
7. My provider gave me advice on what to do if I develop heavy bleeding or need emergency care due to the treatment.
8. Bleeding and cramping do not mean that my pregnancy has ended. Therefore, I must return to my provider's office in about 2 weeks (about Day 14) after I take Mifeprex to be sure that my pregnancy has ended and that I am well.
9. I know that, in some cases, the treatment will not work. This happens in about 5 to 8 women out of 100 who use this treatment.
10. I understand that if my pregnancy continues after any part of the treatment, there is a chance that there may be birth defects. If my pregnancy continues after treatment with Mifeprex and misoprostol, I will talk with my provider about my choices, which may include a surgical procedure to end my pregnancy.
11. I understand that if the medicines I take do not end my pregnancy and I decide to have a surgical procedure to end my pregnancy, or if I need a surgical procedure to stop bleeding, my provider will do the procedure or refer me to another provider who will. I have that provider's name, address and phone number.
12. I have my provider's name, address and phone number and know that I can call if I have any questions or concerns.
13. I have decided to take Mifeprex and misoprostol to end my pregnancy and will follow my provider's advice about when to take each drug and what to do in an emergency.
14. I will do the following:
    - contact my provider right away if in the days after treatment I have a fever of 100.4°F or higher that lasts for more than 4 hours or severe abdominal pain.
    - contact my provider right away if I have heavy bleeding (soaking through two thick full-size sanitary pads per hour for two consecutive hours).
    - contact my provider right away if I have abdominal pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting or diarrhea, more than 24 hours after taking misoprostol.
    - take the MEDICATION GUIDE with me when I visit an emergency room or a provider who did not give me Mifeprex, so that they will understand that I am having a medical abortion with Mifeprex.
    - return to my provider's office in 2 days (Day 3) to check if my pregnancy has ended. My provider will give me misoprostol if I am still pregnant.
    - return to my provider's office about 14 days after beginning treatment to be sure that my pregnancy has ended and that I am well.

Patient Signature:_____ Date:_____

Patient Name (print):_____

The patient signed the PATIENT AGREEMENT in my presence after I counseled her and answered all her questions. I have given her the MEDICATION GUIDE for mifepristone.

Provider's Signature:_____ Date:_____

Name of Provider (print):_____

After the patient and the provider sign this PATIENT AGREEMENT, give 1 copy to the patient before she leaves the office and put 1 copy in her medical record. Give a copy of the MEDICATION GUIDE to the patient.

Rev 2:7/19/05