Adebayo J. Adesomo, 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____

Surburban Women's Family Planning Clinic
3101 Richmond, Suite 250 Houston, Texas 77098
Phone 713–526–6500

INFORMED CONSENT FOR ABORTION, ANESTHETIC, AND OTHER MEDICAL SERVICES

Name ______________________________ Date ____________

Address ____

Town/Village ____________________ State ______________ County ______________

I, ______________________________, am ________ years old, and I request and consent to the performance upon me of a pregnancy termination procedure (abortion) at Suburban Women's Family Planning Clinic by Dr. Adebayo J. Adesomo or Dr. ______________________________

(type or write in the name of a physician who will do the procedure other than those listed)

I also consent that said doctor may preceding, during, and following the operation perform any other procedure or reasonably indicated tests, which he deems necessary or desirable in order to perform the abortion, or correct any other unhealthy conditions he may encounter whether or not related to the presently known condition. If any unforseen event occurs during the abortion, I further request and authorize the doctor to do whatever he may deem advisable or necessary to protect my health, life or welfare, using his professional judgment.

I have fully and completely disclosed my medical histories, including allergies, blood conditions, prior medications or drugs taken, and reactions that I have had to anesthetics, medicines, and other drugs. I understand that the physician treating me is relying upon the honest and complete disclosures which I have made with regard to such information.

I consent that the physician or his associates may administer anesthesia and medications as may be deemed necessary or advisable. I understand that local anesthetics do not always eliminate all pain, that in a few cases local anesthetics may cause severe reactions, and even shock, and that no guarantees or statement to the contrary have been made to me.

I realize that my abortion requires the cooperation of technicians, assistants, nurses and other personnel; therefore, I give my further consent to the administration of medications on my body by all such qualified medical personnel working under the supervision of a Doctor before, during and after this operation.

I understand that the complications associated with pregnancy termination are generally much less severe than with childbirth. Nonetheless, I realize there are risks of complications (both minor and major) which may occur in this surgical procedure, without the fault of the physician. No guarantees have been made to me that I will not suffer a complication. I understand the possibility of perforation of the uterus and internal injuries resulting therefrom. I understand the possibility that not all of the tissue will be removed, that fever may occur, that bleeding may occur during or after the procedure, that infection may occur, and that I may react badly to medicines or the anesthesia; that I may have pain, cramps or even convulsions, and that I may have mild or severe reactions to any of the contraceptives which I use later.

I am aware after reading the attached fact sheet and from the explanation I have received, of the risks involved in an abortion and possible complications. I understand that any questions I have will be answered by my physician and/or counselor, and that I may ask such questions before leaving the office. If I have questions or complications after leaving the office, I agree to call the physician or office at 713–526–6500 immediately.

I understand that the abortion procedure is not fully completed until I have a follow-up check up (this check up must be before my first menstrual period following the procedure) by either my physician or a qualified designated clinician.

I understand that tissue and/or fetal parts will be removed during the procedure, and that I con sent to their examination and disposal by the technician and/or physician in the manner that they deem appropriate. I know that the practice of medicine in surgery is not an exact science; therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurances have been made to me by anyone regarding the operation that I have herein requested and authorized, and furthermore, I understand that when possible, I may be treated for any resulting complications at the office at no charge to me; however, should hospitalization be necessary, I understand that I will be responsible for any and all charges therein.

I agree that any dispute or claim which I may have relating to the abortion, or any related medi cal procedure, or any of the medical personnel performing said abortion or related procedure, shall be determined solely by a decision under the protection and protocols as set forth by the American Arbitration Association.

I certify that I have read and fully understand the above consent to an abortion and the agreement to arbitration, and that all of the above blanks or statements requiring completion are filled in, and that the information placed therein is true and correct to the best of my personal knowledge. I fully understand that the purpose of this procedure is to end my pregnancy and I affirm this to be my personal choice. I know or have had an explanation of other alternatives such as continuing my pregnancy to term. No one has coerced or compelled me to make this decision.

Date: ______________________ Patient's signature ______________________

Witness/Counselor ______________________

Dilation and curettage of uterus (obstetrical)

1. Hemorrhage with possible hysterectomy to control.
2. Perforation of the uterus.
3. Sterility.
4. Injury to bowel and/or bladder.
5. Abdominal incision and operation to correct injury.
6. Failure to remove all products of conception.

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If in the opinion of a physician, hospitalization is required, I hereby give my consent to be transferred to a hospital.

Date: ______________________ Patient's signature ______________________

Witness/Counselor ______________________

Name of Patient: ______________________________

TO THE PATIENT: You have the right, as a patient, to be informed by your physician/practitioner about your condition and the recommended surgical, medical, 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 you may give or withhold your consent to the procedure.

1. I voluntarily request Dr. Adebayo J. Adesomo, MD, FACOG as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

   VOLUNTARY TERMINATION OF PREGNANCY (INTRAUTERINE)

   (ABORTION)

2. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me, and I voluntarily consent and authorize these procedures:

   DILATION & CURETTAGE OF UTERUS WITH SUCTION

   (D & C WITH SUCTION)

3. I understand that my physician may discover other or different conditions that require additional or different procedures than those planned. I authorize my physician and other health care providers to perform such other procedures as are advisable in their professional judgment.

4. **I (do) (do not) consent to the use of blood and blood products as deemed necessary.** _______ PT. INITIALS

5. Any tissues or parts surgically removed may be retained or disposed of by The Methodist Hospital in accordance with its accustomed practice.

6. I understand that no warranty or guarantee has been made to me as to result or cure.

7. Just as there may be 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 realize that, common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the risks and hazards I initial on later pages of this form, and the following risks and hazards may occur in connection with this particular procedure:

   OTHER/ADDITIONAL RISKS:

   CARDIOPULMONARY ARREST NECESSITATING CPR.

   FAILED ABORTION ____ CONTINUATION OF PREGNANCY.

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

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

10. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

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

Date: ____________ Time: ____________ A.M. P.M.

Patient/Other Legally Responsible Person Signature ____________ Translator or Reader Signature ____________

Witness Name ____________ Address (Street or P.O. Box) ____________ City, State, Zip Code

ADEBAYO J. ADESOMO
F.A.C.O.G.
3101 RICHMOND, SUITE 250
HOUSTON, TX 77098

Disclosure and Consent Medical, Invasive and Surgical Procedures

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