

Dear patient,

As a convenience we have provided forms in advance of your appointment. The *medical information* and *consent form* may be completed in your home. Bring the completed forms to the clinic at your scheduled appointment time. Please read all the material completely before you begin your paperwork. If you have any questions one of our staff will be happy to assist you.

INFORMED CONSENT TO TREATMENT, ANESTHETIC, AND OTHER MEDICAL SERVICES

I, _____ AM _____ YEARS OLD, I WAS BORN ON ____/____/____. I AGREE TO HAVE AN ABORTION AT CONCERNED WOMEN'S CENTER BY THE METHOD OF D & C VACUUM ASPIRATION BY DR. NOVICK OR A DESIGNATED ASSOCIATE PHYSICIAN.

PLEASE INITIAL ALL LINES AS YOU READ:

____ 1. I HAVE FULLY TOLD MY PAST AND PRESENT MEDICAL HISTORY, INCLUDING ALLERGIES, BLOOD CONDITIONS, PRIOR MEDICATIONS OR DRUGS TAKEN, AND REACTIONS I HAVE HAD TO ANESTHETICS, MEDICINES, AND DRUGS.

____ 2. The first day of my last menstrual period was: _____. This period was Normal Heavy Light

____ 3. I consent to the physician or his medical attendants giving me such anesthesia or pain killers may be necessary or advisable. I understand that local anesthetics do not always eliminate all pain, and that in a small number of cases local anesthetics cause extremely severe reactions, including rare instances of shock, cardiac arrest, or prolonged unconsciousness and that no guarantees to the contrary have been made to me.

____ 4. I fully understand that the purpose of this procedure is to terminate this pregnancy, and I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term.

____ 5. I further agree to the taking of blood samples, cultures, and other tests and procedures which might reasonably be indicated. I also agree that these tests and procedures might or might not relate to my presently known medical condition. I understand that medical attendants might find such procedures necessary or advisable in the course of my evaluation or treatment and succeeding any complications or treatments.

____ 6. I understand the tissue and products of conception will be removed during the abortion procedure and I consent to having them disposed of by the clinic or physician in a manner they believe appropriate.

____ 7. I understand that the complications associated with abortion are generally much less frequent than with childbirth. I understand that in childbirth some 15 or 20 out of 100,000 women do not survive and that abortion is 5 to 10 times safer. None-the-less, I understand there are risks of minor and major complications which may occur in this as in all surgical procedures. I realize the possibility of a perforation or tear in the uterus or a laceration of the cervix (2 to 4 in 1,000 cases) or of continued ectopic, twins, missed abortion in about 1 out of every 2,000 cases. I understand the possibility that not all the tissue will be removed, that severe bleeding may occur in one or two cases per 100 from various causes such as missed tissue, inability of uterus to contract to normal size, or a tear. I recognize that some possibility of sterility may occur in 1 per 1,000 cases, some of which might arise from a necessary hysterectomy.

____ 8. I understand that if a major complication arises I may have to be hospitalized, the total costs would be my responsibility. I fully understand the possibility of the above mentioned complications and equal or greater risk of continued pregnancy and my decision is to take the former risk, not the latter.

____ 9. I understand also that I may react badly to medicines or the anesthetics, that I may have pain, cramps, or even convulsions, and that I may also have mild or severe reactions to any contraceptives which I may use later. I further realize that such complications may be caused by own exiting medical condition or conduct, or by treatment by a follow-up physician who is unfamiliar with first trimester abortion practice and complications.

____ 10. I understand that the medical practice of my physician is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the United States.

____ 11. The possibility of endometritis and pelvic infection may occur after this procedure requiring antibiotics, hospitalization, and/or surgery.

____ 12. When scheduling my appointment, I received a written statement identifying the Texas Department of Health as the responsible agency for abortion facility complaint investigations. I received this in written form by AAA Concerned Women's Center website, or by email, or by fax. This written statement provided me with a toll free number that discloses information about abortion facilities.

____ 13. I have received after-care instructions regarding an abortion and information regarding possible complications.

____ 14. I understand that any questions I may have will be answered by a physician, nurse, and/or counselor, and I will ask any questions I have before leaving. If I have questions or complications after leaving, I agree to call the clinic at telephone number 713-988-2200 immediately.

I certify that I will have a pelvic examination 21 to 28 days following the termination of pregnancy. I choose to:

____ Return to AAA Concerned Women's Center for this exam.

____ I will see my own physician.

____ I give AAA Concerned Women's Center permission to send a medical report to my physician: _____.

Patient Signature: _____

I have read and fully understand the above paragraphs. A nurse and/or counselor has discussed with me the abortion procedure and the informed consent for the abortion. I fully understand the information that has been presented. On the basis of the information provided, I consent to go forth with the abortion procedure to end my pregnancy.

Signature of Patient _____ Date _____ Time _____ am pm

Witness _____ Date _____ Time _____ am pm

To The Patient: Please be advised that it is necessary to have an ultrasound to evaluate for gestational age and the pelvic region for fibroids and/or cysts which are necessary for the safety of the procedure. The fee for the ultrasound is \$125.00 and is included in the procedure cost. If for any reason we are unable to perform the procedure, the ultrasound fee is non-refundable. AAA Concerned Women's Center will charge only for services rendered (i.e. lab work, counseling, pelvic exam, etc.).

Non-Refundable Services are as follows:

Ultrasound	\$125.00
Basic Labs	\$25.00
Sensitive Urine Test	\$25.00
Counseling	\$25.00
Pelvic Exam	\$35.00
HCG Serum Test	\$40.00 (if necessary)

By signing below, you understand and agree to the above mentioned.

Patient Signature: _____ Date: _____

Additional Notes/Patient Complaints/Phone Calls: _____

(please attach progress notes if more documentation is needed.)

Counseling Comments:

_____ Procedure and precautions explained to patient; options for contraception explained; follow-up instructions provided and verbally reinforced; patient understands all information explained.

Other: _____

Counselor's Signature: _____

LABORATORY

Preg. Test Results Positive _____ Negative _____ Medication Allergies _____

Blood: Hemoglobin _____ RH _____ HCG Serum _____ Other: _____

Comments: _____ Lab Technician _____ Date: _____

PHYSICAL EXAMINATION OR BY HISTORY

BP _____ Pulse _____ Temp. _____ Lab Technician: _____ Date: _____

Heart _____ Lungs _____ Breast _____ Abdomen _____ Pre-Op Pelvic _____

Emotional State _____ Pertinent Medical History _____

Physician Signature _____ Date: _____