

Summit Medical Associates, P.C.

Appointment Information:

What to Expect for a Medical Abortion



Welcome to Summit Medical Associates. We are one of the nation's leading abortion care providers and we strive to provide the highest standard of patient care in a kind and individualized environment. We are a certified and licensed Ambulatory Surgical Center and all of our physicians are board certified obstetrician/gynecologists.

On the day of your appointment, you can plan to be here for approximately 4 to 5 hours. Your appointment will consist of multiple steps that aim to provide you with a high quality of individualized patient care. This handout will explain each of the steps you will take during your appointment. If you have any questions about this handout or the steps you will take, please ask any of our staff members. You may also hold your questions until you meet individually with your health educator. Your satisfaction and comfort are our highest priority.

Video: As you're filling out your paperwork, we'll give you the opportunity to watch a brief video which summarizes all of the steps of your medical abortion process and answers some frequently asked questions. You'll have the opportunity to speak individually with a health educator later on to answer any remaining questions that you may have.

Ultrasound: After completion of your paperwork, a professional ultrasound will be performed to determine how many weeks your pregnancy is measuring. Your ultrasound will be performed abdominally or trans-vaginally. Your ultrasound technician will discuss these methods with you.

Lab Work: A trained lab technician will take your blood pressure, pulse, temperature, perform a urine pregnancy test (if needed), and record your height and weight. She will do a quick finger stick to test your hemoglobin level and RH type. For patients with an RH negative blood test result, you will require additional medication that your lab technician will discuss with you.

Payment: Our finance personnel will explain your fees and answer any questions you may have regarding your payment. We accept cash, Visa, Mastercard, American Express, Discover, and debit cards. No personal checks or money orders are accepted. We accept Blue Cross/Blue Shield and several other forms of private insurance. Please call to verify your insurance before your appointment.

Health Education: You will have a brief informational session with the health educator. During this time, the health educator will answer any questions you may have, and provide you with resources and referrals if requested. She will explain the consent forms you will need to sign and explain the procedure and aftercare instructions. The health educator will also help you to find an effective plan for birth control, if you are interested.

Meeting with the Doctor: After all of your preliminary steps are complete, you'll meet briefly with one of our physicians. He or she will administer the first medication to you, called mifepristone. He or she will also be available to answer any further questions that you may still have. At this time, we will also provide you with all other medications and prescriptions that you'll need for your process. Once you've taken the first medication and all of your questions have been answered, you'll be free to leave.

Our top priority is providing the best medical care and emotional support in a safe environment. For this reason, we do not allow children, purses, bags, or weapons in the building. You may relax in our waiting area and can ask if you would like the television channel to be changed. Thank you for your patience and understanding.

MEDICAL ABORTION RECORD

Name: _____ Date: _____

DOB: _____ Age _____ Last Menstrual Period: _____

HCG _____ HGB _____ Rh type: positive/negative Rhogam given _____ Time: _____

BP: _____/_____ P: _____ TEMP: _____ HT: _____ WT: _____ BMI: _____

Drug Allergy _____ Reaction(s) _____

Drug Sensitivity _____ Reaction(s) _____

Medications currently taken: _____

Signature of Lab Tech: _____

RN Medications administered: _____

Signature of Counselor: _____

Mifeprex Dispensed: 1 dose of one (1) 200mg tablet PO Lot# _____ Exp Date: _____ Initials _____

Mifeprex administered and patient discharged in stable condition: Date: _____ Time: _____ Initials _____

Date Misoprostol to be inserted: _____ Instruction for insertion given _____ Initials _____

Instructions for Misoprostol and Aftercare given: _____ Initials: _____

Physician Notes: Medical history, pelvic ultrasound and lab results reviewed. Patient has been informed of risk and complications and patient desires medical abortion procedure.

Provider's Signature: _____ Date: _____

ULTRASOUND (photo attached)

Gest Sac (MSD): _____ mm = _____	Affix Ultrasound Printout here
CRL: _____ mm = _____	
Additional findings: _____ _____ _____	
Intrauterine: yes / no Gestational Sac: yes / no Yolk Sac: yes / no Cardiac Activity: yes / no Fetal number: 1 2 3 ____	
COMMENTS: _____ _____ _____	
_____/_____/_____	
Ultrasound Technician's Signature	Date Time

SUMMIT MEDICAL ASSOCIATES, P.C.
MEDICAL HISTORY AND ANESTHESIA EVALUATION

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Have you ever had an allergic reaction to any **drug, food** or to **latex**? No Yes (please list): _____

Have you taken any over the counter or prescription medications of any kind in the last week? No Yes (please list, including dosage and when they were last taken): _____

Have you taken any recreational or street drugs (ie. Marijuana, cocaine, etc.) in the last week? No Yes (please list): _____

Type of Anesthesia: General/TIVA (I want to be asleep for my procedure) Local (I want to be awake for my procedure)

Have you or any member of your family ever had any problem with a prior anesthetic? No Yes (please list): _____

Do you currently have any false, capped, loose or chipped teeth? No Yes

Are you wearing contact lenses today? No Yes

Do you have any physical restrictions, limitations, back or neck problems or injuries? No Yes (please list): _____

Pregnancy History: How many times, including this pregnancy, have you been pregnant? _____

of vaginal deliveries: _____ Date of most recent: _____ Complications: _____

of C-sections: _____ Date of most recent: _____ Complications: _____

of previous abortions: _____ Date of most recent: _____ Complications: _____

of miscarriages: _____ Date of most recent: _____ Complications: _____

Have you ever had an ectopic pregnancy? No Yes Have you ever had a molar pregnancy? No Yes

Do you currently have an IUD in place? No Yes

Do you currently have or have you ever had any of the following conditions?

<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Herpes
<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease or Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hypoglycemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	HIV/AIDS
<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke or TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes	Psychiatric Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chlamydia
<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Genital Warts
<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding/Clotting Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	LEEP procedure
<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast Lump or Tumor	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cryosurgery of Cervix
<input type="checkbox"/> No <input type="checkbox"/> Yes	Rh Negative Blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Uterine Ablation
<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma, wheezing or cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis/Cirrhosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cone Biopsy
<input type="checkbox"/> No <input type="checkbox"/> Yes	Smoker	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other Liver Condition	<input type="checkbox"/> No <input type="checkbox"/> Yes	Myomectomy
<input type="checkbox"/> No <input type="checkbox"/> Yes	Drug/Alcohol Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gonorrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tubal Ligation
<input type="checkbox"/> No <input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Syphilis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Uterine Fibroids

Do you have or have you ever had any serious illnesses not listed above? No Yes (please list): _____

Have you had any previous cardiac, abdominal, or female organ surgeries? No Yes (please list): _____

I affirm that all of the above medical information is accurate.

Patient Signature: _____ **Date:** _____ **Time:** _____

Staff Witness: _____ **Date:** _____ **Time:** _____

Contraceptive History

At Summit, we want to make sure your reproductive health needs continue to be met after your abortion. For some women, not getting pregnant again is the most pressing issue on their mind the day of their abortion; for other women it is difficult to imagine being sexually active any time soon after their abortion procedure. We're here to help with whatever your needs are, whenever you're ready.

On the day of your abortion, we can help you start birth control pills, the patch, the vaginal ring, or the depo provera shot. If you're interested in nonhormonal methods like condoms, a diaphragm, or a tubal ligation, let us know and we can talk about how to get started. Your Health Educator will discuss birth control options and, if you choose, will provide you with a method to use after the abortion.

Please circle the method(s) of birth control you used in the past:

Pill Ring Patch Condoms IUD Implant Depo-Provera Withdrawal

Diaphragm/Cervical Cap Spermicide/Sponge Lactation Awareness Method

Emergency Contraception (Morning after pill)

Have you ever had a negative reaction to birth control? (circle one) YES NO

If yes, which method(s)? _____

What was the reaction? _____

Do you have a history of migraine headaches? (circle one) YES NO With aura? YES NO

When, if ever, would you like to be pregnant again? (Please Circle an Option Below)

Immediately Within the next year 3-5 years 5-10 years Never Other: _____

Which birth control method would you be most interested in starting today? _____

How do you normally pay for medications? Circle all that apply:

Medicaid Private Insurance Pay Out of Pocket

Contraceptive Consent

I received information describing the risks and benefits of the contraceptive method of my choice (circle one):

Oral Contraceptive Pill Nuva Ring Depo-Provera Injection Patch

I agree to contact Summit Medical Associates or my primary care physician immediately if complications related to my birth control occur.

I further state that, to the best of my knowledge, I do not have a history of or currently have liver disease or breast cancer.

Lastly, I understand that for women over 30 years of age, smoking cigarettes while using an estrogen containing hormonal birth control, such as the pill or Nuva Ring, results in higher incidents of blood clots, heart attack, and stroke.

Patient Signature

Date

I have reviewed the above information with the patient.

Contraceptive Plan Today: _____ **Long/Medium Term:** _____

Health Educator Signature

Date

SUMMIT MEDICAL ASSOCIATES, P.C.

Name _____ Date _____ Time _____

You will meet with a Health Educator today who will check in with you about how you are feeling and answer any remaining questions you may have. The two of you will discuss the abortion procedure, how to take care of yourself afterwards and any concerns you may have about your abortion. This is a good time to talk about your decision to terminate the pregnancy and any concerns you may have emotionally. Legally we must obtain your written consent for the abortion. An abortion will not be performed on any woman who does not want one, regardless of age. Please answer the following questions as completely as possible.

1. With whom have you discussed your decision to have an abortion? _____

2. Who is supporting your decision? _____

3. Do you feel that anyone is pressuring you into having this abortion? (circle one) YES NO

4. Are you sure that you want to have an abortion? (circle one) YES NO UNDECIDED

5. You will meet with a health educator to discuss your concerns individually or as part of a small group with other patients: Would you prefer to meet (circle one):

INDIVIDUAL GROUP NO PREFERENCE

6. Do you feel that you are in an abusive relationship? (circle one) YES NO

7. Has anyone ever forced you to have sex? (circle one) YES NO

8. What else would you like for us to know? _____

STOP! PATIENT PLEASE DO NOT WRITE BELOW THIS LINE.

Health Educator Notes:

_____ The patient has made her own decision to have an abortion and expresses confidence in that decision

_____ We have discussed support during and after the abortion

_____ The procedure, risks and alternatives were reviewed via: video in person

_____ We have reviewed any questions about the procedure, risks, aftercare and prescriptions

_____ We have discussed birth control methods

Other: _____

A complete description of the abortion procedure, disclosure of the medical risks associated with the procedure, the alternatives to abortion and the name of the physician have been given to the patient.

Patient Signature

Health Educator Signature

RAPID HIV 1/2 TEST CONSENT AND RESULTS FORM

The fee for testing today is \$15. HIV or Human Immunodeficiency Virus is a virus that attacks the immune system, which is the body's natural defense against illness. The HIV virus is found in semen, blood, vaginal and anal secretions, and breast milk. HIV is often contracted through sexual contact and IV drug use. Male/female condoms are the best method of preventing HIV. The earlier HIV is detected the earlier treatment may begin. You must give consent before you receive an HIV antibody test. Your results will remain private, however in the event that you have a positive test result, your information will be released to the Fulton County Health Department.

The INSTI- HIV-1/HIV-2 antibody presents results in one minute. It requires a small blood sample that is acquired through a quick fingerstick. The sample is then combined with a solution and poured into the test membrane. A negative or non-reactive result is shown as one dot with a reactive or positive result showing two dots. **In the event that you have a positive test result, your information will be released to the Fulton County Health Department**

Please Circle One: I ACCEPT or DECLINE HIV Rapid Testing

Name _____ Date of Birth ____/____/____ Age _____ Sex _____ Race _____
County _____ State: _____ Zip: _____

Your Rapid Results Today Are:

NEGATIVE

Your next routine HIV screening is scheduled for
____/____/____

PRELIMINARY POSITIVE

This suggest that HIV antibodies may be present. A second test is needed to confirm this diagnosis

I understand the information on this consent form. I have been given the opportunity to ask questions concerning my voluntary consent to be tested for HIV antibodies. I understand that my consent to be tested can be withdrawn at any time prior to testing.

Client Signature _____ Date _____

Lab Technician _____ Date _____

Please Circle One: I ACCEPT or DECLINE Urine Gonorrhea and Chlamydia Testing

The fee for testing today is \$35. Any valid medical insurance will be billed directly by an outside lab. You will be notified of positive results by a Summit Medical Associates Registered Nurse within 3-10 days. **In the event that you have a positive test result, your information will be released to the Fulton County Health Department**

Client Signature _____

Date _____

Lab Technician _____

Date _____

Consent for Abortion with Mifeprex™ (Mifepristone) and Misoprostol

I, _____, hereby give permission for Summit Medical Associates, P.C., and/or such associates and assistants as he/she may select and supervise to perform a nonsurgical/medical abortion with mifepristone and misoprostol.

Description:

I understand that I am fewer than 10 weeks pregnant, and I have decided to have an abortion with the medications Mifeprex™ and misoprostol. These medications will cause an abortion by starting cramping and bleeding from my vagina like a very heavy period or miscarriage. This method allows a pregnant woman to have an abortion without putting instruments into the uterus.

Mifeprex™ is a drug which blocks the action of progesterone, a hormone needed to continue a pregnancy. Mifeprex™ has been approved by the U.S. Food and Drug Administration (FDA) for early abortion, and has been used by millions of women in Asia and Europe (it has been referred to as “RU486” or the “French Abortion Pill”). Misoprostol is a drug used in the United States to prevent irritation or ulcers in the stomach of people using aspirin or aspirin-like pain medicine. When the FDA approved Mifeprex™, it was approved for use in combination with misoprostol. Studies have shown that Mifeprex™ and misoprostol, when used together, are approximately 95% effective in causing an abortion in early pregnancy. Taking the Mifeprex™ begins the abortion. No evidence based way to reverse Mifeprex™ exists.

Procedure: *This description of the procedure follows the evidence-based regimen which is an alternative to the FDA-approved regimen.*

1. The provider will take my medical history and examine me to assess how many weeks pregnant I am. An ultrasound will be done to determine how far along my pregnancy is. The ultrasound may be done by putting the ultrasound probe in my vagina or on my abdomen. I will have my blood drawn to check my blood type and test for anemia.
2. I will swallow mifepristone 200 mg. This day will be called “day 1.”
3. I will return home, and 24-48 hours later, I will take 4 pills of misoprostol (800 mcg) buccally or vaginally.
4. I understand I will have access to a telephone and my provider’s 24-hour emergency contact information.
5. I will contact my provider at 404-607-0042 if: I soak 2 or more maxi pads per hour for 2 consecutive hours; I have a sustained fever (100.4°) or onset of fever a few days after misoprostol; I have severe abdominal pain not helped by pain medication; or I have no bleeding within 24 hours after misoprostol insertion, which may require more medication or evaluation for an ectopic pregnancy.
6. If I have cramping in my lower abdomen, I may take hydrocodone, which will be prescribed to me. I may also take ibuprofen for cramping. If I have nausea, I may take Phenergan, which will also be prescribed to me.
7. I will return to the office around day 14. This follow-up visit is very important to confirm that termination of my pregnancy has occurred and that there have been no complications. At this visit I may have an ultrasound, a physical examination, or another blood test. If my abortion has occurred, then I am done. If the pregnancy is still growing, then I will either need to repeat the medical abortion process or have a surgical abortion. I understand there is a chance there may be birth defects if the pregnancy is not ended after taking mifepristone and misoprostol. I understand if I am unable to return to the office for follow-up, I may take an at-home pregnancy test 4-6 weeks after taking the misoprostol to confirm I am no longer pregnant. I understand that it is normal to have a positive pregnancy test immediately following an abortion, but that it should become negative by week 6. I will call or otherwise notify Summit Medical of my negative pregnancy test, or else I will be called by a representative of Summit to confirm I am no longer pregnant.

Risks May Include:

1. Incomplete abortion: As with a surgical abortion, some pregnancy tissue may remain in my uterus. If this occurs, the provider will discuss my treatment options, which include waiting 1 or more weeks, using more misoprostol, or having an aspiration, which is similar to a surgical abortion. If I decide to wait or use more misoprostol, and the abortion still is not complete, I will need an aspiration curettage. The risks of an aspiration curettage include a risk of making a hole in the uterus, tearing of the cervix, adverse reaction to anesthesia that may be used, infection, excessive bleeding, and failure to remove all of the tissue from the uterus.
2. Vaginal bleeding: As with a surgical abortion, heavy bleeding can occur and blood clots may come out of my vagina. If I

have extremely heavy vaginal bleeding or dizziness, an aspiration curettage may be necessary to stop the bleeding. The risks of an aspiration curettage are stated above. The risk of having very heavy vaginal bleeding after using Mifeprex™/misoprostol is about 1 per 100 (1%). The risk of needing a blood transfusion after using Mifeprex™/misoprostol is about 1 per 1,000 (0.1%).

3. Continued pregnancy and birth defects: My pregnancy may not end after receiving the medications. If this happens, birth defects are possible. Because of the risk of birth defects, I consent to a surgical abortion in the event that the medical abortion is unsuccessful. The risks of a first-trimester surgical abortion include a risk of making a hole in the uterus, tearing of the cervix, adverse reaction to anesthesia that may be used, infection, excessive bleeding, and failure to remove all of the tissue from the uterus.
4. Side effects: The following side effects are possible: nausea, vomiting, diarrhea, fever, headaches, and chills. Most of these side effects last less than a day. I will have cramping in my lower abdomen, and I may need pain medication for this reason.
5. Ectopic Pregnancy: A rare condition which is a complication of pregnancy rather than abortion is ectopic pregnancy or a pregnancy in the fallopian tube. I understand that if the pregnancy is in the fallopian tube or outside the uterus, neither surgical abortion nor a Mifeprex™/misoprostol abortion will remove the pregnancy, and that due to the possible threat of rupture of the fallopian tube, hospitalization may be necessary as soon as it is discovered.

Costs and Payments:

I have paid in full for the medication abortion, and this fee includes payment for the surgical abortion IF needed. The fee does not include charges incurred for an emergency room visit or for care at another facility.

Voluntary Consent:

I have been informed of other choices during early pregnancy including continuing the pregnancy and becoming a parent, continuing the pregnancy and making adoption arrangements, and surgical abortion. I have been informed of the risks involved with a surgical abortion and a medical abortion, and the risks involved with continuing the pregnancy. I understand that I may choose to have a surgical abortion at any time after I start the medical abortion, although I will need to pay for this care if it is not medically necessary.

I have fully disclosed my medical history including the date of my last menstrual period, allergies, blood conditions, prior medications or drugs, and reactions to medications or drugs. I certify that I have read this form or it has been given to me. I understand its contents, and any questions have been answered to my satisfaction. I certify that I have been given the Mifeprex™ Medication Guide and that I have had an opportunity to read it and discuss it with my provider.

I will be given the choice of buccal or vaginal misoprostol rather than the FDA-approved regimen of buccal misoprostol. Current research shows both methods are safe and effective, and the vaginal route causes less stomach upset. I understand this alternative, evidence-based regimen is different from the regimen outlined in the Mifeprex™ Patient Agreement, and, based on conversations with my provider and the information he/she has given me, I have chosen the method best for me.

PATIENT SIGNATURE

DATE

TIME

PATIENT NAME (PRINT)

WITNESS SIGNATURE

DATE

TIME

WITNESS NAME (PRINT)

Healthcare Providers: *Counsel the patient on the risks of Mifeprex*. Both you and the patient must sign this form.*

Patient Agreement:

1. 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.
2. I understand:
 - a. I will take Mifeprex on Day 1.
 - b. My provider will either give me or prescribe for me the misoprostol tablets which I will take 24 to 48 hours after I take Mifeprex.
3. My healthcare provider has talked with me about the risks including:
 - heavy bleeding
 - infection
 - ectopic pregnancy (a pregnancy outside the womb)
4. I will contact the clinic/office right away if in the days after treatment I have:
 - a fever of 100.4°F or higher that lasts for more than four hours
 - severe stomach area (abdominal) pain
 - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
 - stomach pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol
5. My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away my healthcare provider has told me who to call and what to do.
6. I should follow up with my healthcare provider about 7 to 14 days after I take Mifeprex to be sure that my pregnancy has ended and that I am well.
7. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with Mifeprex and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
8. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.
9. I have the MEDICATION GUIDE for Mifeprex. I will take it with me if I visit an emergency room or a healthcare provider who did not give me Mifeprex so that they will understand that I am having a medical abortion with Mifeprex.
10. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name (print):** _____ **Date:** _____

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 Mifeprex.

Provider's Signature: _____ **Name of Provider (print):** _____ **Date:** _____

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.

Summit Medical Associates, P.C.

1874 Piedmont Road

Atlanta, GA 30324

(404) 607-0042

MEDICAL ABORTION AT-HOME INSTRUCTIONS

1. Although some women report no symptoms at all from the pill that you have taken today, you may experience increased nausea or some bleeding and cramping. Even if you feel you have passed tissue before taking the second medication, you should still take the Misoprostol on day 2 or 3. You will be given an antibiotic that you should take on the same day that you take your Misoprostol.
2. Wash your hands before you insert the four Misoprostol tablets into your vagina. Then, insert the pills one at a time, pushing them in as far as is comfortable.
3. You need to lie flat for about an hour after the insertion to be sure that the pills stay in. If the pills fall out before an hour, you will need to reinsert them. The pills will dissolve and sufficient absorption will occur within the first hour. It is ok if pill residue comes out if an hour or more has passed.
4. You have been given prescriptions for pain and nausea medications. Please get them filled to have on hand for the day that you insert the Misoprostol. We recommend that you take the pain and nausea medications one half hour before you insert the Misoprostol because the medications will work better if taken in advance.
5. You will experience heavy bleeding and cramping and may pass clots while you are passing the tissue. This is normal. If your bleeding becomes so heavy that you are completely saturating two pads in one hour for two consecutive hours, you should call us. Use a heating pad, hot water bottle, or massage to relieve the discomfort. Some women find it helpful to get up and walk around.
6. Try to find a comfortable place to rest and relax during this process. Make sure to check your bleeding periodically and place something under you in case you bleed through your clothing.
7. You may eat during this process. Some women experience nausea and vomiting. If this happens, continue taking your nausea medication and try to stay hydrated and eat small, light snacks. Call us if you are unable to hold down fluids for more than four consecutive hours.
8. If you have any concerns or complications, the after-hours emergency service is available 24 hours. Call our regular number 404-607-0042. The answering service will pick up and ask the nature of your emergency. They will take your phone number and the on-call nurse will return your call as soon as possible.
9. Complications include: heavy bleeding that is soaking a pad twice in one hour for two consecutive hours, a fever of 100.4° or higher that lasts longer than four hours, or a foul-smelling discharge. While cramping is normal, please call if the cramps are unbearable and the pain medication is not helping.
10. Remember: Part of the procedure is the follow-up visit. It is important for your health that you return to us for a follow-up to be certain you are not continuing your pregnancy. Bleeding and cramping do not mean the pregnancy has ended. A continued pregnancy has a VERY HIGH PROBABILITY of having severe birth defects. If you are unable to return for a follow-up visit, you may take an at-home urine pregnancy test after day 28 to confirm that you are not continuing your pregnancy. **It is normal to have a positive pregnancy test immediately following a successful abortion, but the result should become negative by day 28.**

Signature

Rev: 06/16/2016

Date

Time

SUMMIT MEDICAL ASSOCIATES, P.C.

1874 Piedmont Avenue NE, Suite 500-E | Atlanta, GA 30324 | 404-607-0042

In-Office Procedure Authorization for Treatment

Name of Patient: _____ Date: _____ Chart # _____

I hereby authorize and consent to the following examinations, as necessary, to determine if I am medically eligible for an abortion at Summit.

**PLEASE
INITIAL
ALL**

- _____ I consent to laboratory examination of my urine.
- _____ I consent to venipunctures or finger sticks to obtain blood samples.
- _____ I consent to an intrauterine ultrasound examination to determine fetal sizing.

I hereby certify that I am signing this authorization in the following capacity:

**PLEASE
INITIAL
ONE**

- _____ An adult consenting for herself
- _____ A parent or guardian consenting for her or his minor dependent
- _____ A minor (under 18) with consent of parent or legal guardian
- _____ A minor (under 18) with a court-ordered judicial bypass
- _____ A minor (under 18) with a marriage certificate
- _____ A minor (under 18) whose parent or guardian has been notified 48 hours in advance

Patient Signature _____ Date _____ Time _____

Parent or Guardian Signature _____ Date _____
(if patient is a minor)

Clinic Witness Signature _____ Date _____

- _____ Driver's License
- _____ State-Issued ID
- _____ Passport
- _____ Military ID
- _____ Marriage Certificate
- _____ Judicial Bypass
- _____ Yearbook/School ID
- _____ Birth Certificate
- _____ Other: _____

Clinic Witness
Copy of Checked Item is Attached

SUMMIT MEDICAL ASSOCIATES, P.C.

Patient Contact Information

Patient Name _____ Date _____

Home Address _____

City _____ State _____ Zip Code _____

Work Address (optional) _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____

Note: Please give at least one phone number and mailing address.

Federal privacy rules require that you tell us how to contact you with information, lab results, appt. changes, and other information that is crucial to your care with us. Please check all that apply:

The best way to telephone me is (**please check two**):

Call my

- Home
- Cell
- Work

Please say

- "Summit Medical Associates called"
- "your doctor's office called"
- "Casey called" (our code for the clinic)

The best way to mail information to me is (**please check two**):

Mail my

- Home
- Work

Return address?

- Return address on envelope is OK
- No return address on envelope please

Other ways to contact me:

- You can email information to me at this address: _____

I understand staff may periodically need to contact me about test results or other information about my care with **Summit Medical Associates**. I have made my preferences known about how to contact me.

I also understand that critical situations may arise that requires **Summit Medical Associates** to make contact with me quickly. If unable to do so, I understand that **Summit Medical Associates** may send certified mail to my home address as a way to make direct contact with me. By signing below I agree to **Summit Medical Associates'** contact procedures.

Patient Signature

Witness (clinic staff)

Parent/Guardian

Date/time (clinic staff)

State of Georgia Induced Termination of Pregnancy (ITOP) Worksheet

The Georgia Department of Public Health requires us to submit the following information. Your name will not be attached to this report. Please answer the following questions to the best of your ability. If you are unsure about specific dates, please give your best estimate.

1. What is your date of birth? ____/____/____
2. Are you married? No Yes Declined to indicate
3. What is your zip code? _____
4. What city or town do you live in? _____
5. What state do you live in? _____
6. Do you live within your city limits? No Yes Unknown
7. When was the first day of your last normal menstrual period? ____/____/____
8. Is this your first pregnancy? (If yes, you may skip 9-13). No Yes
9. How many pregnancies have been full term (resulting in vaginal delivery or C-section)? _____
10. Are any of your full term pregnancies no longer living? If so, how many? No Yes _____
11. Have you ever had an abortion before? If so, how many? No Yes _____
12. Have you ever had a miscarriage? If so, how many? No Yes _____
13. When was the date of your last vaginal delivery or C-section? ____/____/____
14. When was the date of your last miscarriage or abortion? ____/____/____
15. Do you have a history of Alcohol or Drug abuse? No Yes Declined to indicate
16. What is the highest level of education that you've completed? _____

17. Are you Hispanic/ Latina?

- Unknown Refused No, not Hispanic/ Latina Yes, Mexican, American, Chicana Yes, Puerto Rican Yes, Cuban
- Yes, Other Hispanic/ Latina (Please Specify): _____

18. What is your race? Please check any that apply to you:

- Unknown Refused
- White Asian Indian Chinese Filipino Japanese Korean Black/ African American Vietnamese Native Hawaiian Guamanian/ Chomorro Samoan
- American Indian/ Alaskan Native (please specify): _____
- Other Asian (please specify): _____
- Other Pacific Islander (please specify): _____
- Other (please specify): _____

Patient Rights

Effective April 14, 2003

In accordance with the Federal Privacy Law (HIPAA):

Right to Access Records

Patients have the right to see and get copies of their records within thirty (30) days of request. The patient has a right to see anything in the record. Copies of the patient record may be made and will be charged at the going rate of twenty five dollars (\$25.00) plus any postage costs for mailing records. Copies made for a third party may be higher.

Right to Request Restrictions

Patients have the right to request restrictions on who sees their records. Any request that is unreasonable will be dealt with on an individual basis.

Right to Confidential Communication

Patients have the right to receive communications about their record in a confidential manner. In this office patients will be given a form to fill out stating how they would like to be contacted.

Right to Amend the Record

Patients have the right to amend their records when they disagree with the content but physicians have the right to deny these requests. A record cannot be changed but a line may be drawn through the disputed entry. The physician may then write an addendum.

Right to an Accounting of Disclosures

Patients have the right to know everyone to whom the office discloses record information for purposes other than treatment, payment, and health care operation.

A log, as required by HIPAA, will be kept showing each disclosure and the person to whom it is made. This will also show what information is provided and the purpose. This office will only log in the releases for which the patient's authorization is required.

Right to File Complaint

You have the right to file a complaint against our facility through the Division of Healthcare Facility Regulation if you believe you received poor quality care. You may file a complaint by writing the Georgia Department of Community Health, Division of Healthcare Facility Regulation, 2 Peachtree Street, NW Atlanta, GA 30303. You may also call the Complaint Intake Unit at 404-657-5726 or 404-657-5728.

Any questions about this policy can be directed to Summit Medical Associates' Privacy Officer.

PATIENT SIGNATURE

SUMMIT MEDICAL ASSOCIATES, P.C.

PATIENT CERTIFICATION FOR ABORTION

Appointment Date: _____

Chart #: _____

Patient Name: _____
 First Last

Birth Date: _____

I, _____, request that an abortion be performed on me today,
 (please print name)
_____. I certify that:
 (today's date)

1. At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or his or her qualified agent (which could be a patient educator, licensed psychologist, licensed social worker, licensed professional counselor, licensed assistant, physician, or registered nurse) has told me, by telephone or in person,
 - The particular medical risks for me associated with the particular abortion procedure that will be used to end my pregnancy;
 - The probable gestational age of the embryo or fetus at the time of the abortion;
 - The medical risks associated with continuing the pregnancy to term;
 - That medical assistance benefits may be available for prenatal care, childbirth and neonatal care;
 - That the father will be liable to assist in the support of the child; and
 - There are printed materials that describe the fetus, list agencies that offer alternatives to abortion, and contain information on fetal pain and a state-sponsored website (dph.georgia.gov/womens-right-know-wrtk) on which these materials may be reviewed.
2. I was provided the opportunity to ask questions about the abortion that will be performed, and all of my questions about the abortion have been answered to my satisfaction.
3. I consent to the particular abortion voluntarily, knowingly, intelligently, and without coercion by any person, and I am not under the influence of any drug of abuse or alcohol.
4. I have signed this consent and certification form prior to the abortion.

Patient Name Printed: _____

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

SUMMIT MEDICAL ASSOCIATES, P.C.

I _____ understand that Summit Medical Associates is not responsible for any money or valuables that I may possess. I understand that money and valuables (jewelry, etc.) are not allowed in the surgical area. I affirm that I am not taking any money or valuables to the counseling area, the pre-operative area, the operating room, or the recovery room. Any money or valuables have been either returned to my car or given to my driver.

Patient Signature

Date

Witness

Date