

Summit Medical Associates, P.C.

Appointment Information:

What to Expect for a Surgical 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 5 to 8 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 surgical 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.

Pre-Operative Waiting Room: You will change into a medical gown and relax in a reclining chair in the pre-operative waiting room. This is where you will wait to have your procedure. When it is time for your procedure, a health worker will escort you to the surgical suite.

Surgical Abortion Procedure: A surgical abortion procedure, performed in an ambulatory surgical center, is one of the safest medical procedures you can have. There are several different types of abortion procedures performed at our clinic, and your health educator will discuss the procedure that is best for you. The procedure itself is very quick, ranging from 5 to 15 minutes. All of our procedures are performed under either general or local anesthesia by a trained physician, and your health educator will assist you in picking which type of anesthesia is best for you.

Recovery Room: Once your abortion is complete, you will be transported to the recovery room. Registered nurses and health workers will monitor your vital signs for 30 to 45 minutes. A health worker will help you get up and dressed. You will be given a light snack while you wait to be discharged from our clinic. Your aftercare medication and instructions will be reviewed with you before you leave. Please read these instructions carefully to ensure a quick healing process. If you have any questions after you leave our clinic, please do not hesitate to call: (404) 607-0042.

A Note to Drivers: It is our commitment to take good care of your partner, friend, or loved one. This appointment can take anywhere from 5 to 8 hours, and in some cases, a little longer. We ask for your patience and

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cooperation so that we may provide an extremely high standard of care to your loved one. If you need to leave for any period of time during the appointment, please check in with our front desk. You will need to sign a form at the beginning of the appointment and provide your picture ID. If you are assisting the patient with payment and plan to leave for any period of time, make sure your loved one has everything she needs to make the payment. If using a credit card with your name on it, you must either be present, or fill out a credit card authorization form. Lastly, if your loved one is receiving sedation today, you must be available to pick her up when she is discharged. If there are any questions you have or anything we can do to make your wait more comfortable, please let a staff member know.

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.

15 – 18 Week Dilation and Evacuation (D&E) Procedure:

If you are measuring between 15 to 18 weeks, it is possible you may be eligible for a one-day procedure. This is completely dependent upon physician evaluation, medical history, and/or previous caesarian or vaginal deliveries. Please keep in mind that this will be a longer appointment, as you will need to be medicated for several hours.

Cytotec: Cytotec is a medication that is administered buccally, which means it will sit in the space between your gum and cheek for 1 to 3 hours. A nurse will give you this medication, and will instruct you on what to do. After you have sat for as long as prescribed, you will be able to wash your mouth out. Cytotec helps to soften and ripen the cervix, which may cause some cramping, slight discomfort, or nausea.

Laminaria Insertion: The procedure your physician will perform involves laminaria, a type of sterile, surgically prepared seaweed, which is inserted into the cervix. These dilators will absorb moisture and gently dilate the cervix for three hours. A registered nurse will offer you pain medication and anti-nausea medication in order to make the laminaria insertion as comfortable as possible. Inserting laminaria is very quick, and takes about 5 minutes. You can expect an experience similar to a pelvic exam and menstrual cramps.

D&E Procedure: After you have sat for the right amount of time with the Cytotec and/or laminaria, you will be ready to have your procedure. A health worker will escort you to the surgical suite, where you will receive general anesthesia, which is an IV sedation. The abortion procedure takes 7 to 10 minutes and you will be completely asleep for the duration of the procedure.

17 – 20 Week Overnight Dilation and Evacuation (D&E) Procedure:

If you are measuring between 17 to 20 weeks, it is likely you will be eligible for a two-day (overnight) procedure. You will not need to stay at the clinic overnight, but for your safety you will need to stay close to the clinic at your own home, a friend or family member's home, or a hotel. Please keep in mind you will need to return to the clinic first thing in the morning, so it is important to have someone to drive you on both days.

Laminaria Insertion: On the first day of your appointment a registered nurse or physician will insert several dilators into your cervix called laminaria. These are about the size of matchsticks and are made of sterile, surgically prepared seaweed. Before inserting the laminaria, the nurse will give you pain medication to ease any discomfort. Laminaria insertion takes about 5 minutes. Following the insertion, some women will need an additional step performed to prepare their bodies for the procedure. This is determined by ultrasound measurements. If this additional step is necessary for you, your health educator will provide you with more information. After this procedure, the nurse will review your overnight instructions and medications. She will also give you a time to return to the clinic the next morning.

D&E Procedure: When you return to the clinic on the second day, the lab technician will check your blood pressure and temperature and will assist you in changing into a medical gown. Depending on your ultrasound measurement, you may also receive another ultrasound. You will also receive pre-procedure medications and fluids that will be explained to you before they are administered. The abortion procedure will take only 10 to 20 minutes and you will be completely asleep during your procedure.

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 _____

Summit Medical Associates, P.C.

1874 Piedmont Road | Suite 500-E | Atlanta, GA 30324 | (404) 607-0042

DOs & DON'Ts AFTER ANESTHESIA OR SEDATION

After receiving anesthesia or sedation during a surgical procedure, you can play an active role in your recovery by heeding the straightforward list of dos and don'ts that follows:

DON'Ts AFTER ANESTHESIA OR SEDATION

Don't drive a car for at least 24 hours.

After anesthesia or sedation, your reactions and judgment may be impaired. Such impairment makes driving a car dangerous to you and to others. It is especially important that you do not forget to arrange for someone else to drive you home from the clinic.

Don't operate complex equipment for at least 24 hours.

The same logic that applies to driving a car similarly applies to the operation of other equipment. This includes equipment used at home, such as a lawn mower, as well as that which is used on the job.

Don't take any medication unless prescribed by or discussed with your physician.

Some medication may adversely interact with anesthetic drugs or chemicals remaining in your body. Included are prescription drugs, such as sleeping pills or tranquilizers, and over-the-counter medications, such as aspirin.

Don't drink alcohol for at least 24 hours.

Alcohol is also considered a drug, meaning that an alcoholic drink has the potential to negatively react with the anesthetic in your system. This includes hard liquor, beer, and wine.

DOs AFTER ANESTHESIA OR SEDATION

Do leave the clinic accompanied by a responsible adult.

This person will ensure that you travel home safely, as well as provide immediate care at home. We recommend that you have this adult with you for 24 hours after surgery.

Do remain quietly at home for the day and rest.

You need rest both because you have received anesthesia or sedation, and because you have undergone a surgical procedure—even one that is considered minor. If, after a day, you still do not feel recovered, you may want to continue your rest for an additional day or two.

Do take liquids first and slowly progress to a light meal.

Heavy foods can be difficult for your system to digest, thereby increasing the chance for discomfort. For your nourishment, start by taking liquids, then eat light foods, such as broth or soup, crackers or toast, plain rice, Jello, and yogurt.

Do call the clinic if you have any questions.

We are interested in your welfare and want your care to go as planned. If you have questions or feel your recovery is not progressing to your satisfaction, call the clinic.

I have read and understand the above safety information regarding anesthesia and conscious sedation.

Patient Signature

Date

Witness

Date

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 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.

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

SUMMIT MEDICAL ASSOCIATES, P.C.

ANESTHESIA PREOPERATIVE ASSESSMENT

Name: _____ **Date:** _____

Allergies: _____

Pertinent Medications: _____

Untoward Reaction from Previous Anesthesia: _____

Recent Anesthesia: _____

Type of Anesthesia Requested by the Patient: General Mac Other Counselor/NP Initials: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Anticipated Anesthesia Problems: _____

Type of Anesthesia Discussed with Patient: General Mac Other ASA: _____

Remarks: _____

CRNA: _____ Time: _____

Summit Medical Associates, P.C
Consent to Outpatient Surgery

(Vacuum aspiration (VA) or Dilation & Evacuation (D&E)
VOLUNTARY INTERRUPTION OF PREGNANCY

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

I, _____, Age _____, hereby give my consent to and request and authorize

Dr. _____ and assistant of his/her choosing to perform an ABORTION on me without coercion.

PATIENT Initial boxes as you read

DIAGNOSIS: Tests and/or examinations have indicated that I am pregnant.

PURPOSE OF ABORTION: I understand the purpose of the abortion is to end my pregnancy.

PROCEDURE: It has been explained, and I understand, that the operation consists of stretching open the cervix and using surgical instruments to remove the contents of my uterus.

ALTERNATIVES: I understand that the alternatives to abortion are either to have the baby and keep it, or have the baby and place it for adoption. I understand that the referrals for these alternatives are available to me here today upon my request. I have considered and rejected these alternatives and request that the abortion procedure be performed on me.

I UNDERSTAND AND ACCEPT THE FOLLOWING MATERIAL RISKS OF SURGERY: Surgical abortion is one of the safest types of medical procedures. Complications from having an abortion are less frequent and less serious than those associated with giving birth. However, as a result of surgical procedures, there may be material risks of: infection, allergic reaction, disfiguring scars, severe loss of blood, loss of or loss of function of a limb or organ, paralysis, paraplegia or quadriplegia, brain damage, cardiac arrest or death. In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:

- a. Possible perforation (a puncture or tear) of the uterus and/or other organs (less than 0.4% of cases) which may be repaired with stitches. This may heal itself or may require surgical repair or, rarely, hysterectomy;
- b. Possible injury to the cervix, uterus, fallopian tubes, and/or bowel and or adjacent organs;
- c. Possible formation of blood clots accumulating in the uterus, requiring another suctioning procedure (less than 0.2% of cases);
- d. Excessive bleeding including possible hemorrhage, necessitating possible need for transfusion. (.02% - 0.3%)
- e. Possible DIC (disseminated intravascular coagulation);
- f. Possible fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder or ureter.
- g. Possible emboli (clots of blood or other material that might travel to other parts of the body);
- h. Possible incomplete abortion, which might require additional surgery. In some instances, all tissue may not be removed, an incomplete abortion will result and the procedure may have to be repeated.
- i. Possible cervical incompetency (I understand that the abortion procedure may result in cervical incompetency which means that I may have problems maintaining a pregnancy in the future (possible miscarriage, stillbirth), or low birth weight, premature delivery, or other complication in pregnancy);
- j. Possible emotional distress such as depression or other psychological consequences may occur. I understand that I may call the facility for further follow-up counseling;
- k. Infection, most of which are easily identified and treated if the woman carefully observes follow-up instructions, (0.1% - 2%) In order to avoid this complication, I agree to take the precautions explained to me and listed in the post-operative instructions;
- l. Continued Pregnancy: In rare cases, a woman can still be pregnant after an abortion. Possible causes include a twin or multiple pregnancy, early pregnancy, ectopic or tubal pregnancy, or abnormality of the uterus. In the event of continued pregnancy, another abortion procedure may be required.
- m. Possible need for immediate surgery or other additional surgery which might include a hysterectomy (removal of the uterus, fallopian tubes and/or ovaries), laparoscopy (examination of internal organs) and laparotomy (repair of perforation).

CESAREAN SECTION (C-SECTION): I understand that a previous c-section increases the likelihood of abnormal placentation (a pregnancy within the c-section scar or a placenta that is imbedded in the wall of the uterus). I understand that abnormal placentation increases the likelihood of hemorrhage. I understand that scar tissue from a previous c-section may make the pregnancy difficult to access, resulting in an incomplete abortion, and that it may weaken the uterus, increasing the likelihood of perforation or heavy bleeding. I understand that the greater the number of previous c-sections, the greater the likelihood that a complication may occur.

PROGNOSIS: The likelihood of success of the above procedure is good () fair () poor () provided aftercare instructions are followed and follow up care is obtained. I understand that if I do not have the abortion procedure, the prognosis (predicted future medical condition) is continued pregnancy with the risks of the same.

ECTOPIC PREGNANCY: (pregnancy outside of the uterus) I understand that in some instances the pregnancy can be outside of the uterus. In most cases of ectopic pregnancy the pregnancy is in the fallopian tubes leading to the uterus. I understand that an abortion procedure cannot terminate such a pregnancy, and that due to the threat of rupture of the fallopian tubes, immediate hospitalization may be necessary. I understand that an ectopic pregnancy is not a complication of an abortion, but rather a condition that would have already existed prior to the abortion.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure. I understand that the physician, medical personnel and other assistants will rely on statements I have made, the medical history I have given and other information in determining whether to perform the procedure or the course of treatment for me and I warrant that I have made full, complete and truthful disclosure.

Summit Medical Associates, P.C
Consent to Outpatient Surgery

PATIENT Initial boxes as you read

ADDITIONAL PROCEDURES: If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgment decides that a different or additional procedures including but not limited to anesthesia or blood transfusion or the association of another doctor, or hospitalization at a hospital may be necessary, I give my consent to such. I assume all financial responsibility for payment for additional services. I give my permission for my parents (or legal guardian where applicable) or other person (name set forth below) to be notified by the doctor or staff member. The correct identity, address, and phone number of my emergency contact is set forth below.

LABORATORY: I consent to diagnostic studies, tests, sonograms, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis of my condition or procedures set forth herein. I understand that the purpose of a sonogram here is to determine gestational size only and NOT to rule out or determine fetal abnormalities or deformities. I also consent to the disposal of any tissue or other parts of the contents of my uterus (womb), which may be removed during the abortion in the discretion of the physician or the center. I also consent to the administration of RhoGam (or equivalent) should my blood be Rh negative. I agree that the doctor or clinic staff may need to contact my emergency contact or me regarding additional laboratory findings. My confidentiality will be respected where possible.

EMERGENCY: If I develop a fever, heavy bleeding, severe cramping, pain, water breaking, or any other symptom, I agree to notify SUMMIT at once. I have been given an emergency telephone number, which I can call 24 hours a day for assistance. My failure to give notice releases the doctor or clinic from any responsibility to me.

FOLLOW-UP: I have been advised that a follow-up examination is unnecessary with a routine, uncomplicated abortion. However, I understand that a follow-up examination is available to me at SUMMIT, free of charge, should I have any complications or concerns after my abortion. I understand this visit is available within 4-6 weeks after today. I agree to follow the post-abortion instructions provided to me and to take my medications as directed. I understand that if I choose to seek follow up care at another facility, this will be at my own expense. My failure to obtain care, when experiencing a problem or complication, relieves the doctor and the clinic of any responsibility to me.

By signing this 3-page form, I acknowledge that I have read or had this form explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in before I signed this form. I also have received additional information including but not limited to the materials listed relating to the procedure described herein.

I voluntarily consent to allow Dr. _____ or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

I acknowledge and understand that any pregnancy tissue removed during the abortion becomes property of Summit Medical Associates; to dispose of in accordance with Georgia law, unless I have requested otherwise in writing.

If I am treated after the abortion by anyone other than Summit, I, _____, (last four of SS# _____), (DOB _____ - _____ - _____) authorize such other providers to release my medical records to Summit, although this release is signed prior to receiving said other services; for the purpose of continuity of care. I approve using a photocopy of this release to obtain such records. If I choose to be treated after my abortion by a provider other than Summit, I release Summit for any liability of care. By my signature and initials I verify that I have read (or had read to me), give permission and understand the above informed consent.

I authorize Summit Medical Associates to release my medical records pertaining to this procedure; to any provider providing follow up care from this procedure, for the purpose of continuity care related to the abortion.

Benefits:

Statistically, 1 out of 3 U.S. women will have an abortion by the age of 45. Women have different reasons for pursuing abortion. Some of the things people consider when choosing this option are:

1. **Safety:** Abortion is one of the most common procedures performed in the U.S. with significantly low complication rates and safety record compared to carrying a pregnancy to term.
 2. **Current and Future Plans:** Some women are not ready to be a parent or think that parenting would make it difficult to continue pursuing work or school.
 3. **Current children:** A woman might feel that another child would interfere with her ability to care for her current children.
 4. **Health:** Some women choose to terminate for their own physical or mental health. Others may terminate based on health problems of the fetus.
 5. **Financial:** Some women cannot or do not wish to incur the cost of raising a child.
 6. **Support:** Some women do not want to raise a child on their own or feel that their current situations are not conducive to parenting.
 7. **Rape or Incest:** Some women have become pregnant without their consent.
 8. Some women simply do not want to be pregnant at this point in their life.
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The following are additional steps that MAY need to be taken prior to your abortion procedure. These steps may be taken due to the gestation of your pregnancy, specific indications in your medical history, or individual physician protocols. A health educator will review any of these steps with you if they pertain to your care today and have you initial any that apply to indicate your understanding.

Before having the procedure, your cervix may need to be dilated (opened) so that the procedure can be accomplished in the safest way possible. There are different ways that a cervix can be dilated. **Risks of dilation** can include: damage to the cervix or uterus, rupture of amniotic fluid and/or premature expulsion of the pregnancy, infection or serious allergic reaction.

PATIENT Initial boxes as you read

CYTOTEC/MISOPROSTOL: The clinician may have me place pills in my cheek or she may place them in my vagina. This medication may sometimes be used alone or in addition to osmotic dilators to help with cervical dilation. Side effects of this medication can include minimal to moderate cramping and gastrointestinal symptoms, such as vomiting or diarrhea. If you reach what you feel is an intolerable level of discomfort, please alert the nurse. If for any reason, you are unable to do the procedure following the administration of this medication, there will be an increased risk of miscarriage and/or birth defects.

CERVICAL OSMOTIC DILATORS (C.O.D.) are small sticks that are placed in the cervix. They may be made of a sterile, surgically prepared seaweed, Laminaria, or a synthetic material, Dilapan. Many times, they are left in place overnight to achieve the best outcome. Minimal to moderate cramping should be expected. It has been explained to me that one or more C.O.D. (which has been shown to me) may be inserted into the cervix in order to open it gently and slowly. I understand that once the C.O.D. is inserted the abortion procedure has begun. I will not leave the center until I am discharged by the staff. I understand that each C.O.D. has a string, which may protrude from the vagina and that I am NOT to pull on the string(s). The C.O.D. absorb moisture and enlarge the opening of the cervix and this may cause cramping and/or bleeding. The benefit of C.O.D. is to make the abortion procedure easier and reduce the possibility of complications. C.O.D. may be inserted if my pregnancy is measuring at 15 or more weeks.

DIGOXIN INJECTION (20+ WEEKS): I may or may not receive an injection in my abdomen today to cause demise in the fetus. This would cause the fetal heart to stop. If I am receiving an injection of Digoxin, the physician will listen to my heart first. Side effects may include nausea, blurry vision, and lightheadedness. Risks include: premature expulsion of the pregnancy, infection and the very rare risk of cardiac arrest. To the best of my knowledge, I have no known allergy to Digoxin nor do I have Wolff-Parkinson-White Syndrome. I agree to return to Summit Medical Associates, P.C. for the abortion procedure under general anesthesia.

Patient Signature _____ Date _____ Time _____

NOTIFY IN CASE OF EMERGENCY

Name Telephone

PARENT CONSENT/GUARDIAN CONSENT

I am the _____ to the patient whose name appears above. I have read and had explained to me that matters set forth in the above and hereby request and give my consent. I agree to pay for medical expenses incurred in this or as a result of this procedure.

Telephone Parent, Guardian Signature Date Time

TRANSLATOR

I (please print your name) _____, am the translator for the patient whose name appears above. I have read, accurately translated and explained the information contained in this Consent to Abortion form to the patient named above. I have relayed her questions to the counselor and translated the answers

Telephone Translator Signature Date Time

HEALTH EDUCATOR

I have reviewed this consent form with the patient.

Staff Witness signature Date Time

SUMMIT MEDICAL ASSOCIATES, P.C.

POST-OPERATIVE INSTRUCTIONS

Abortion is a relatively simple procedure, and you should return to normal very quickly. Complications are rare, but if a problem should arise, please call our facility Monday-Friday between the hours of 9am and 5pm.

Emergency calls may be made 24 hours a day. If you experience abnormal bleeding, temperature over 100.4°, or unusual pain, call us immediately. Care by a competent abortion care provider is an important factor in your recovery.

Telephone: 404-607-0042 or 1-800-537-2985

PRECAUTIONS:

1. **BLEEDING** varies from woman to woman. Some women have no bleeding post-operatively. Usually bleeding is similar to a period. It may last off and on for 4-6 weeks. It may be bright red, dark red, or brown. Bleeding is not normal if you are saturating a maxi pad in 1 hour for 2 hours. If you are bleeding this much, you need to call the facility or our answering service immediately.
2. **CLOTS:** Some blood clots are normal, especially after lying down for a while. If you pass clots that are golf-ball sized or larger, along with heavy bleeding and cramping, please call us.
3. **CRAMPING IS NORMAL FOLLOWING AN ABORTION.** Although some women have no cramping at all, others do experience moderate cramping. If you have had a number of pregnancies or have fibroids or endometriosis, your cramping may be heavier. Use the prescription medication we have given you, a heating pad or hot water bottle, or whatever medication you use for menstrual cramps. **DO NOT USE ASPIRIN;** this will cause you to bleed more. Cramping may be on and off for a couple weeks.
4. **CHECK YOUR TEMPERATURE** if you feel like you have a fever or chills. Infection can occur following an abortion. If you have a temperature over 100.4° (just a little over 100°), please call the facility, drink fluids, and take 2 Tylenol.
5. **ACTIVITIES:** You may return to work or school the following day. If you need an excuse for “light duty”, please ask staff in Recovery before you are discharged.
6. **HYGIENE: NOTHING IN YOUR VAGINA FOR ONE WEEK.** This includes intercourse, tampons, and douching. Showers, tub baths, and swimming are fine.
7. **SEXUAL RELATIONS:** No intercourse for one week. This is to prevent infection and another pregnancy. It is possible to become pregnant again almost immediately following the abortion. Ovulation tends to occur 10-14 days post-abortion.
8. **POST-ANESTHESIA:** It is normal to feel sleepy and tired after being put to sleep. It will gradually wear off in the next 8 hours. The best thing to do is to lie down and take a nap when you get home. For 24 hours (until anesthesia is completely out of your system), do not drive, operate machinery, make important decisions, or **DRINK ALCOHOL.**
9. **NUTRITION:** You may eat or drink as normal when you return home. It is a good idea to drink a lot of fluids (water, not soda) to rehydrate your body after fasting. Constipation may occur. You may use Milk of Magnesia or a bulk laxative (Citrucel). Greasy or fried foods may not agree with you for 24 hours. Your hormones may cause some nausea and vomiting or morning sickness as they did when you were pregnant. These symptoms should start getting better in the next 24-48 hours.
10. **BREAST CARE:** For women in the second trimester, your breasts may be tender and/or leaking milk for up to a week. Wear a sports bra or a snug-fitting bra 24-hours a day for the next week. You may use soft, gel ice packs or cabbage leaves for the discomfort. Do not stimulate your breasts or attempt to express the milk, as this will cause your breasts to continue making milk. The milk and/or swelling will go away within the week.
11. **EMOTIONS:** Occasionally women feel “blue” or depressed after having an abortion. These emotions can be caused by the abrupt hormonal changes which follow the procedure. As your body returns to its normal hormonal cycle, these feelings will go away. However, if you continue to have these feelings for more than a few days, or they get worse, feel free to call your Health Educator here at this facility. She may be able to help you sort out your feelings or refer you to a counselor near your home.
12. **BIRTH CONTROL:** If you are going to use birth control pills, the patch, or the ring, you may start them the day of, or the day after your procedure.
13. **PRESCRIPTIONS:** You will receive medications after your abortion to prevent infection and assist with pain. Please review the medication instruction sheet and medication labels in order to correctly take the medicines. If you have any questions about how medications should be taken, please call our facility.
14. **CHECK-UP:** A follow-up examination is unnecessary with a routine, uncomplicated abortion. However, if you experience a complication or concern, please know a follow-up examination is available at Summit free of charge.

Patient Signature

Date

Time