AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT

This form documents your consent for induced termination of pregnancy, any related treatments and follow-up treatments needed. This legal and ethical document ensures you understand your rights and the medical procedures/treatments that Falls Church Healthcare Center (FCHC) will provide you. You can review and sign these forms electronically or in person. You will have additional opportunities before treatment for your questions to be answered to your satisfaction.

PATIENT NAME:______________________________DATE OF BIRTH:____________AGE: ____

MY INITIALS INDICATE MY UNDERSTANDING, AUTHORIZATION AND/OR CONSENT

PART I. GENERAL INFORMATION:

_________ As the patient, I have the right to receive information about my health condition and the plan of the medical care to be provided by Falls Church Healthcare Center's (FCHC).

__________ I agree to talk with the Patient Educator or clinician to review my health condition and the procedures and treatments Falls Church Healthcare Center (FCHC) plans for my care, as well as the alternatives, benefits, risks and side effects that may be associated with my planned care.

_________With pregnancy, there are three options to consider: abortion, adoption and parenting. There are two ways to have an abortion: Medication Abortion (using medicines) and Procedural Abortion (using aspiration). I will discuss these options with the FCHC staff.

_________ I may change my mind any time prior to receiving the first medication before my chosen procedure.

_________ FCHC Medical Staff can disclose all or any part of my medical record 1) to assist in my continuing care or treatments, 2) as required by Virginia Department of Health, compliant with HIPPA and 3) as required by my insurance company, IF I've authorized FCHC to bill for services. I may revoke this authorization by providing written notice to FCHC.

_________ FCHC (through its secure vendor texting service) can contact me by SMS text message. Texting may include appointment reminders and other care-related messages. Your phone number will never be released to outside parties. To opt-out of SMS text messages I may reply STOP at any time or provide written notice to FCHC.

__________ In consideration of the services rendered and received, I agree to pay Falls Church Healthcare Center in accordance with the service fees applicable. Payments for completed medical, counseling, telehealth and laboratory services are non-refundable.

Part II. MEDICAL CARE INFORMATION:

_______ I reviewed **Alternatives, Benefits, Risks and Side Effects** that may be associated with my planned care**, the Anesthesia Consent, Discharge and Follow-up Instructions** and videos available on FCHC's Patient Portal. I can review this information again with a FCHC Patient Educator via telehealth or in person. I may request and receive copies of this information about my medical care.

_______ All medical procedures have known and unknown risks. Whether my pregnancy ends by abortion, miscarriage, or childbirth – risks (complications) are possible though rare, including risks of death though extremely rare. Complications of pregnancy, including death are greater from childbirth than from induced abortion.

_________ I will disclose all medications and drugs I use to the patient educator or clinician. Using methadone, methamphetamine, heroin, cocaine and other drugs may increase side effects from medication and anesthesia risks.

Part III. DECLARATIONS AND CONSENT:

_______ After considering the alternatives, benefits, risks and side effects, I request abortion services.

IF I qualify, I request to have:

_______Aspiration Procedural Abortion (Awake) with a local anesthetic administered by a licensed physician

_______Aspiration Procedural Abortion (Asleep) with Intravenous (I.V.) sedation administered by a licensed anesthesia clinician

_______Medication Abortion with mifepristone/misoprostol dispensed by a licensed physician

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Part III Declarations and Consent (continued)

_______ Other or different conditions requiring additional or different procedures or tests than planned may be discovered during the procedure. I understand, whenever possible, these findings will be discussed with me. I consent to provision of those services to ensure my wellness.

_________ Medications can be administered to abort my pregnancy safely. Medications will be identified and explained prior to administration.

_________ **Ultrasound**: An ultrasound may be performed to assure the pregnancy is in the uterus (not ectopic) and confirm gestational age. This ultrasound does not determine if the pregnancy is healthy nor the gender. I can be advised if the pregnancy is single or multiple. *I want to know if my pregnancy is multiple:* ☐ **No** ☐ **Yes**

_________ **Pain Control**: Local anesthetic (lidocaine) or I.V. sedation (propofol) is available for pain relief during aspiration abortion. Risks from I.V. sedation are rare and will be reviewed by the FCHC anesthesia clinician. I will not drive a car, operate machinery or make important decisions until the morning after receiving I.V. sedation.

_______ I will disclose all medications and drugs I use to the patient educator or clinician. Using methadone, methamphetamine, heroin, cocaine and other drugs may increase side effects from medication and anesthesia risks.

_________ **Laboratory:** I consent to necessary tests that may include Rh typing.

_________ I agree to the administration of Rh immune globulin (Rhogam) if I my blood type is Rh negative, *or* I can sign a form to refuse. I understand there is a charge for Rhogam.

_________ In accordance with the customary and usual medical practice FCHC will dispose and/or may test any tissue removed during the procedure.

_________ FCHC Medical Director Daniel Noonan MD and/or other FCHC Clinicians and medical assistants can provide my requested medical care, treatments and procedures. FCHC is a teaching facility, so I understand that medical residents, medical students, clinical externs and/or Doulas, will observe and/or participate in my care under the direction and supervision of the FCHC Clinician.

_________ I may withdraw my consent at any time prior to receiving the first medication before my chosen procedure.

_________ I will call FCHC at 703-532-2500 (daytime number) for unanswered questions, concerns or if I have a medical problem, or the after-hours telephone number (410-631-1600) for urgent medical issues.

_________ If I seek emergency treatment or continuing care elsewhere, I understand the cost or fees may be my responsibility (if not covered by insurance).

_________ No licensed clinician has or can make any promise or guarantee regarding the end results of medical care or abortion.

_________ I have sufficient information to give my informed consent to medical treatment and care. All my questions have been answered to my satisfaction.

_________ My initials **on each blank** indicate I have read (or had read to me), I understand, and I agree with each statement initialed.

_________ **My signature below indicates I consent and authorize FCHC to provide the care, procedures and treatments requested or indicated above.**

PRINT YOUR NAME: I, ____(print name)

have read and understand this form. All information I have given is true and correct. I realize the clinician and FCHC rely on my providing complete and accurate information. All my questions have been answered to my satisfaction. I give my consent voluntarily. No one is forcing or coercing me. A copy of this Informed Consent will be provided to me at my request.

SIGN HERE:____ ___________ (Date)

If e-signed in advance, please initial here day of procedure _________________________ *___________ (Date)*

CLINICIAN ATTESTATION: This consent, procedure(s), alternatives(s) and risk(s) were reviewed with the patient who signed above. This patient has told me they understand to their satisfaction and directed me to proceed.

Signature of Provider ______________________________________ ____________ ***(Date)***