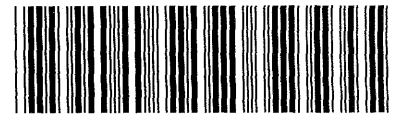


Obstetrics & Gynecology Associates, P.A.

specializing in
*Obstetrics, Gynecology, Infertility
and Laser Surgery*



REGISTRATION SLIP

Date _____

NAME _____
(last) (first) (middle)

ADDRESS _____ Apt#: _____
(city) (state) (zip code)

TELEPHONE _____ EMAIL _____

CELL PHONE # _____

AGE _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

SPOUSE'S NAME _____ SS# _____

D.O.B. _____ SPOUSE PHONE# _____

PARENT'S NAME IF MINOR _____

PATIENT'S OCCUPATION _____

EMPLOYED BY _____
(telephone) (ext.)

MEDICAL INSURANCE

PRIMARY: Name of Company _____ Insured's Name _____
Policy # _____ Group # _____

SECONDARY: Name of Company _____ Insured's Name _____
Policy # _____ Group # _____

RELATIVE NOT LIVING IN YOUR HOME WHOM WE MAY CONTACT IN CASE OF EMERGENCY

NAME _____ PHONE # _____
(last) (first) (middle)

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection

ASSIGNMENT OF BENEFITS

I hereby authorize Obstetrics and Gynecology Associates, P.A., to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such surgical or medical care. I also authorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

I agree that Obstetrics and Gynecology Associates, P.A. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

(Please print name)

(Signature)

Consent:

1. I, _____, give permission for the person(s) listed below, to accompany me in the exam room, to pick up **any** medical records on my behalf, and to speak with any employee over the telephone, **with the full knowledge that any and all past and present medical history may be divulged.**

- _____ - **Accept (If you checked Accept, please fill in names below)**
_____ - **Decline**

Last name, First name

Relationship

Last name, First name

Relationship

Last name, First name

Relationship

Medical Malpractice Insurance

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

OUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

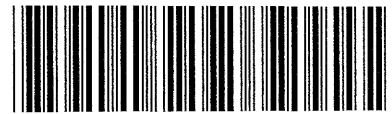
Florida Statute 458.320(5)(g)(1)

I, _____, have received and read the above statements.

Signature: _____

Date of birth: _____

Date: _____



Name:

DOB:

Date:

Obstetrics & Gynecology Associates, P.A.
2400 North Orange Blossom Trail, Suite 300
Kissimmee, FL 34744
407-846-7200
Fax: 407-846-3989

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

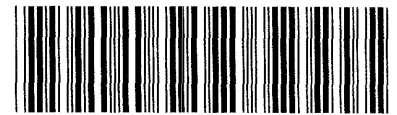
Dated: _____

Patient or Patient's Representative: _____

Print Patient's Name: _____

If signed by Representative, state name of Representative: _____

Relationship to Patient: _____



GYNECOLOGIC INTAKE HISTORY

NAME: _____ BIRTHDATE: _____ DATE: _____
 ADDRESS: _____
 HOME TEL: _____ WORK TEL: _____
 EMPLOYER: _____ INSURANCE: _____
 NAME OF SPOUSE/PARTNER: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Currently	Past	Notes
1. Constitutional Weight loss Weight gain Fever Fatigue	_____ _____ _____ _____	_____ _____ _____ _____	
2. Eyes Double vision Spots before eyes Vision changes	_____ _____ _____	_____ _____ _____	
3. ENT/Mouth Ear aches Ringing in ears Sinus problems Sore throat Mouth sores Dental problems	_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____	
4. Cardiovascular Painful breathing Chest pain Difficulty breathing on exertion Swelling of legs Palpitations of heart	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	
5. Respiratory Wheezing Spitting up blood Shortness of breath Cough, chronic	_____ _____ _____ _____	_____ _____ _____ _____	
6. Gastrointestinal Diarrhea, frequent Bloody stool Nausea / vomiting Constipation	_____ _____ _____ _____	_____ _____ _____ _____	
7. Genitourinary Blood in urine Pain in urination Urgency Frequency of urination Incomplete emptying Stress incontinence Abnormal periods Painful intercourse	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	
8. Musculoskeletal Muscle weakness	_____	_____	
9. Skin / breast Pain in breast Discharge Masses Rash Ulcers	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	

NAME: _____

DOB: _____

DATE: _____



REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Currently	Past	Notes
10. Neurological			
Dizziness	_____	_____	
Seizures	_____	_____	
Numbness	_____	_____	
Trouble waling	_____	_____	
11. Psychiatric			
Depression	_____	_____	
Crying, frequent	_____	_____	
12. Endocrine			
Dry skin	_____	_____	
Abnormal thirst	_____	_____	
Hot flashes	_____	_____	
13. Hematologic / Lymphatic			
Bruises, frequent	_____	_____	
Cuts do not stop bleeding	_____	_____	
Enlarged lymph nodes	_____	_____	
14. Allergic / Immunologic			
Allergies	_____	_____	
Drugs, other	_____	_____	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	Yes	No	MAJOR ILLNESSES	Yes	No
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression / anxiety		
Kidney Infections / stones			Anemia / Blood transfusions		
Tuberculosis			Seizures / convulsions / epilepsy		
Venereal Disease			Bowel Trouble		
Heart Trouble / murmur			Glaucoma		
Diabetes			Arthritis / joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis / Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS / HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES / ILLNESSES

Reason	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB / GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

Patient Information Sheet

Patient Name: _____ Date: _____
 Date of Birth: _____

Who have you chosen as your Pediatrician? _____
 What is your racial origin? Caucasian African American Hispanic Asian Other

How many pregnancies have you had? _____
 How many babies did you carry full term? _____
 How many premature deliveries have you had? _____
 How many abortions have you had? _____
 How many miscarriages have you had? _____ How many weeks at the time? _____
 How many ectopic pregnancies have you had? _____
 How many multiple births have you had? _____
 How many living children do you have? _____
 When was your last menstrual period? _____ (State Unsure if not known)
 Were you on any type of birth control when you became pregnant? Yes No
 At what age did you begin your menstrual cycle? _____
 Are your periods regular (once a month)? Yes No
 How long do your periods last? _____
 Have you taken a pregnancy test? Yes No When was your first positive test? _____

List below information from your last pregnancies:

	1 st	2 nd	3 rd	4 th	5 th	6 th
Date month/year of Delivery?						
How many weeks at the time of delivery?						
How many hours were you in labor?						
Baby's birth weight?						
Male/Female?						
Type of Delivery? (Vaginal or Cesarean)						
What anesthesia (if any) was used?						
Delivering hospital?						
Did you deliver premature? If yes, did you take progesterone injections?	/	/	/	/	/	/

List any complication you may have had with any of the above pregnancies/deliveries:

- | | |
|---|--|
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Take baby aspirin, Lovenox, Heparin during pregnancy. |
| <input type="checkbox"/> Other | |

Past Medial History:

Do you have a history of any of the following? If yes, please give date you were first diagnosed and list any treatment or medication you may be taking:

	<u>Yes:</u>	<u>No:</u>	<u>If Yes, Explain:</u>
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heart disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Autoimmune disorders:	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Kidney disease/Urinary tract infections:	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Neurologic/Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Psychiatric/Depression:	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Hepatitis/Liver disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Varicosities/Phlebitis:	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Thyroid dysfunction:	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Trauma /Domestic violence:	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. History of blood transfusion:	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Tobacco usage:	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Street drugs:	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Pulmonary (asthma/tuberculosis):	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Allergies (Drugs/Latex):	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Breast disease/cancer:	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Gynecologic surgery:	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Operations/Hospitalizations:	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Anesthesia complications:	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. History of abnormal pap:	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Uterine anomaly/D.E.S.:	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Infertility:	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Cancer of breast, ovary, or uterus.	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Twins	<input type="checkbox"/>	<input type="checkbox"/>	_____
29. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

List below any symptoms you may have experienced since your last menstrual period (Example: nausea, headache, fever):

Please indicate below if you or your family (Patient, baby's father, or anyone in either family) has a history of any of the following: If yes, describe in the comments area below:

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Your age will be over 35 years when you deliver this baby?
<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia (Italian, Greek, Mediterranean, or Asian background) MCV-DO
<input type="checkbox"/>	<input type="checkbox"/>	Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Tay-Sachs (ED, Jewish, Cajun, French Canadian)
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease (African)
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis

- Huntington Chorea
- Mental Retardation/Autism
- Other inherited genetic or chromosomal disorder
- Maternal metabolic disorder (PKU, Insulin dependent diabetes)
- Patient or baby's father had a child with a birth defect.
- Recurrent pregnancy loss or stillborn.
- Medication/alcohol/street drugs since last menstrual period.

Comments: _____

Yes **No**

- Do you have or have you been treated for Hepatitis A,B, or C?
- Do you live with someone with TB (tuberculosis)?
- Have you ever been exposed to TB?
- Have you or your partner ever had Genital Herpes?
- Have you had a rash or viral illness since your last menstrual period?
- Have you ever had an STD (sexually transmitted disease)?
- Have you ever had the Chicken Pox?
- Do you have cats?

Comments: _____

Pre-Pregnancy weight? _____ Height? _____
 Are you allergic to any medication? Yes No
 Are you against receiving blood transfusions? Yes No
 Have you felt the baby move? Yes No If yes, When was the first time? _____
 Have you had an ultrasound? Yes No If yes, When: _____ Where: _____
 Have you been treated by any other physician for this pregnancy or seen at the Emergency room?
 Yes No If yes, When and Where? _____

Patient Acknowledgement:

Obstetrics and Gynecology Associates are entering into a physician/patient relationship with you. We are reviewing your medical history and assessing our ability to care for you during you pregnancy. We are also agreeing to accept your insurance for the duration of this pregnancy. Therefore, if your situation should change, medically or financially, we may need to re-evaluate our relationship with you and it is possible that you may be transferred out of our care if your new situation warrants a change.

Complications of pregnancy can require advanced treatment. There are physicians in our community, maternal fetal medicine specialists, who specialize in complicated, high risk pregnancy. If your pregnancy requires this type of treatment, we may refer you to a maternal fetal medicine specialist for consultation or, if necessary, for the duration of your pregnancy.

Our contractual relationship with many insurance companies limit the number of patients we may treat at any one time. For instance, we are limited in the number of patients we can care for with some insurance. If you change to one of theses companies mid-pregnancy, we may need to ask that you leave the practice.

Please sign below to indicate that you completed the above information to the best of your knowledge and have read and understand the patient acknowledgement.

Patient Signature

Date

Obstetrics & Gynecology Associates, P.A.

specializing in
*Obstetrics, Gynecology, Infertility,
and Laser Surgery*

Douglas G. Winger, M.D., FACOG
Deanna Hobby, ARNP-C
Lorene Duncan, PA-C

Juan Reinoso, M.D., FACOG
Dawn Schwartz, ARNP-C

Meredith Tittsworth, WHNP-BCC

This informed consent document discusses the risk and benefits of the different ways to deliver a baby, including vaginal delivery, vacuum delivery, forceps delivery and cesarean delivery. While most deliveries are joyous events, unfortunately certain high risk conditions, or just the process of having a baby, may lead to unforeseen complications. We believe the pregnant women and their families should be aware of the different routine deliveries, so that they may make an informed decision regarding this pregnancy. As always, please ask any questions you may have. Please do not sign this form until you have read it and understand its contents.

Vaginal Delivery

I understand that vaginal delivery may have unpredictable and unforeseen complications. Some of the possible complications of vaginal delivery include (not limited to):

Shoulder dystocia (after the delivery of the baby's head the shoulders of the baby are trapped in the vagina). This is an unforeseen and unpredictable event. It is an emergency that can lead to partial or total brain damage due to lack of oxygen or physical damage to the baby. This includes but not limited to damage to the nerves that control the arms and hands, the spinal cord, and the baby's neck, scalp, and collar bones.

Placental Abruption (separation of the placenta from the inside wall of the uterus), this can lead to severe blood loss, coagulation disorders, maternal death, and lack of oxygen to the baby, fetal death, and permanent brain damage. Often this can lead to vaginal bleeding, but not always.

Uterine atony (the uterus will not contract properly after delivery or after cesarean section). This could lead to profuse bleeding with the need for a blood transfusion, emergency hysterectomy and prolonged recovery in the hospital or intensive care unit.

Postpartum bleeding due to retained placental tissue. Despite careful technique, a small piece of placenta may remain stuck to the inside wall of the uterus after delivery. This could lead to uterine bleeding requiring uterine curettage. This procedure may not stop the bleeding for a variety of reasons (placenta accrete, uterine atony, etc.) requiring hysterectomy (removal of the uterus). One of the possible consequences of such a curettage is the development of intrauterine adhesions or a possibility of future infertility.

Nerve injuries due to position, compression or effort during the delivery process. These injuries may make it difficult to walk, and may require consultation with a neurologist (nerve specialist) and may lead to long term use of crutches, walkers, or other assisting devices.

Although controversial, there is some evidence that urinary incontinence and pelvic prolapse, where the muscles surrounding the vagina weaken, are more common after vaginal delivery than cesarean delivery. However, just being pregnant regardless of the type of delivery, may lead to an increased risk of urinary incontinence. During vaginal delivery, the baby may create a tear between the vagina and anus, an area called perineum. The tear may occur spontaneously, or via an episiotomy. Tears and episiotomies might have consequences including, but not limited to, scar tissue formation with painful sexual intercourse, the formation of fistula (a hole between the vagina and rectum where gas or feces escapes into the vagina uncontrollably), infection, bleeding, and even fecal incontinence.

VACUUM AND FORCEPS DELIVERIES

A vacuum extractor is a plastic cup your doctor applies to the top of the baby's head to help deliver the baby vaginally. Forceps are metal instruments that your physician places alongside the baby's head to help guide the baby through the vagina. There are many reasons why a vacuum or forceps delivery may be warranted. Your physician will discuss these with you at the time of delivery. However, on occasion the baby's heart rate will drop dangerously at the time of delivery, or there will be profuse bleeding. Both of these are emergencies. Some patients wish for their doctor to deliver the baby vaginally if at all possible. Due to the need to deliver the baby fast as possible, it may be necessary to use the vacuum extractor or forceps. Some patients prefer this over a cesarean delivery, whereas other patients do not want their physician to use a vacuum or forceps, and prefer a cesarean delivery.

It is always preferable to discuss these issues with your doctor prior to the time of an emergency, because it can be hard to concentrate when, for example, you are bleeding or your baby's heart rate is abnormal. We encourage you to ask any questions you may have. Vacuum and forceps each have possible risks and benefits. Vacuum devices have a higher chance of bleeding of the baby's scalp or brain and the development of jaundice. Forceps have a higher chance of damage to the mother's vagina and anus with the potential for fecal incontinence or formation of a fistula. Both have a higher chance of shoulder dystocia than spontaneous vaginal delivery and cesarean.

The risk of bleeding into the baby's brain, although uncommon, is somewhat higher for vacuum deliveries than the forceps deliveries. It is least common for planned cesarean deliveries, slightly more common for spontaneous vaginal deliveries, and more common for forceps and vacuum deliveries.

CESAREAN DELIVERY

Cesarean deliveries, sometimes called "cesarean sections," involve making an incision into the lower abdomen and delivering the baby by abdominal surgery. As described above, there are several risks versus benefits one should consider when comparing cesarean delivery to vaginal delivery. Although controversial, cesarean delivery likely decreases the risk to the baby of shoulder dystocia and injury to the baby during delivery. Cesarean delivery may also decrease the risk of developing urinary and rectal incontinence. However, cesarean delivery may lead to more babies needing respiratory care after delivery due to amniotic fluid within the lungs.

Cesarean delivery is a major surgical procedure, which, along with all surgical procedures, has certain risks and benefits. These include but are not limited to infection, profuse bleeding (which may require a blood transfusion and removal of the uterus, called a hysterectomy), blood clots in the legs, pelvic area, abdomen, and lungs, pneumonia, damage to internal organs like the bladder, intestines, female organs, or muscles and nerves, and the potential for the incision to open up after the procedure. All of these may require a longer time in the hospital or intensive care unit, or the need for further surgery or procedures. Unfortunately, undergoing a cesarean delivery may leak scar tissue within the abdomen or uterus, making it harder to get pregnant in the future. Also, such scar tissue may lead to abdominal pain and painful intercourse. The need for blood transfusion or blood products may increase the risk of acquiring AIDS, hepatitis and other transmissible diseases. In addition, having a first cesarean delivery increases the risk of later uterine rupture during vaginal delivery and may lead to future cesarean deliveries.

Patient Signature _____ Date _____
Relationship to patient if not patient

Witness _____ Date _____

Consent for Testing:

Patient Name: _____

Cystic Fibrosis:

I the patient acknowledge that the physicians at Obstetrics and Gynecology Associates have offered the Carrier Screening for Cystic Fibrosis. I have been given information about this test and I understand that the purpose of this test is to determine if I am a carrier of Cystic Fibrosis. All of my questions about this test have been answered.

- I Do wish to have the CF test performed. _____ **Initial**
- I Do Not wish to have the CF test performed. _____ **Initial**

HIV:

* This statement is to be used for pregnant women who object to HIV testing.

I the patient have been counseled about the benefits of HIV testing and have been offered the test. I have been counseled about treatment available to reduce the transmission of HIV from HIV infected women to their babies. With that knowledge, I hereby decline HIV testing.

I decline HIV testing _____ **Initial**.

NT Screening:

I the patient acknowledge that the physicians at Obstetrics and Gynecology Associates have offered me the Nuchal Translucency Screening also known as NT. I have been given information about this test, and I understand that the purpose of this test is to screen for birth defects of m unborn child. These birth defects include Down Syndrome, Trisomy 13, Trisomy 18 and other chromosomal abnormalities. I am aware this screening is not 100% accurate and further testing might be offered, if my test has an increase risk. The NT consist of blood work and a sonogram. We verify with your insurance if this screening is covered by your insurance, however this is never a guarantee of benefits until the claim is received and processed. We must send the blood work to a special lab, which your insurance might not cover. I, the patient take full responsibility of all fees pertaining to this screening if my insurance does not cover it. All of my questions about this screening have been answered.

- I Do wish to have the NT screening performed. _____ **Initial**
- I Do Not wish to have the NT screening performed. _____ **Initial**

Quad Screening:

I the patient acknowledge that the physicians at Obstetrics and Gynecology Associates have offered me the Quad Screening. I have been given information about this test, and I understand that the purpose of this test is to screen for birth defects of my unborn child. These birth defects include Down Syndrome, Trisomy 18, and Neural Tube Defects. All of my questions about this test have been answered.

- I Do wish to have the Quad Screening performed. _____ **Initial**
- I Do Not wish to have the Quad Screening performed. _____ **Initial**

Patient Signature

Date

Witness Signature

Date

Obstetrical Information Consent:

Patient Name: _____

1. I the patient understand that Obstetrics and Gynecology Associates have many providers. Dr. Reinoso, Dr. Winger and Judy Siron, CNM are the three providers who deliver babies in the practice. One of these providers will be on call on the day that I go into labor and any of them may deliver my baby. I agree to allow these providers to share in my care during my pregnancy.
_____ **Initial**

2. There is a charge to complete all disability and FMLA forms. The charge is \$15.00 per form. It will be necessary to pay the fee prior to forms being release to you. Please allow 5-7 business days for completion of forms. Due to HIPPA forms may not be faxed and will require you to come to the office to obtain forms.
_____ **Initial**

3. I have been given information regarding Seprafilm Adhesion Barrier. I have read and understand the information about Seprafilm that I have been given. I have been given the opportunity to ask any questions I may have regarding Seprafilm. I understand that, should I have a cesarean section delivery, my physician my place Seprafilm Adhesion Barrier in my abdominal cavity to help prevent the formation of scar tissue after my procedure.
_____ **Initial**

4. Obstetrics and Gynecology Associates provide obstetrical delivery services at Florida Hospital Celebration. We do not regularly staff any other Osceola County hospital for obstetrical care. A patient who requires emergency room care should proceed to Florida Hospital Celebration if she desires our physicians to care for her. Patients who visit any other hospital will be treated by staff physicians at the hospital and our physicians will NOT likely be notified that the patient is in the emergency room. Our physicians prefer to be involved in every part of your medical care. They encourage you to visit Florida Hospital Celebration for any medical need you may have during your pregnancy.
_____ **Initial**

5. Due to Florida Hospital Celebration guidelines, all scheduled deliveries, whether by induction or by cesarean section, will be allowed only after the patient has reached a gestational age of 39 weeks or greater. We will not be allowed to schedule your delivery prior to 39 weeks unless medically necessary. But, if you go into labor on your own, this restriction does not apply.
_____ **Initial**

I have read the above information and understand the guidelines of the practice.

Patient Signature

Date

Witness Signature

Date