

EXHIBIT “C”

PATIENT: Maura Mena
DATE OF BIRTH:
MEDICAL RECORD: 68838
DATE: 08/02/2013
VISIT TYPE: Medication Abortion

Subjective History

37 year old
Gravida: 8 P: 3 SAB: 1 TAB: 3 ectopic: 0.

LMP: 06/25/2013.

Reason(s) for Visit

1. Medication Abortion

Services/supplies offered

Emergency contraception was offered. NA to offer.
STI testing was offered. NA to offer.
HPV was offered. NA to offer.
Condoms were offered. Client accepted

MAB Contraindications and Special Considerations Screening

IUC not in place
Can follow-up to confirm pregnancy terminated
Willing to have vacuum aspiration
Access to telephone, ER care
Not breastfeeding
No drug/alcohol use in last 24hrs

Ultrasound Screening

Primary purpose: Pre MAB
Patient informed that US is for gestational dating only
No history of scarred uterus
Patient desires to see ultrasound image
Patient desires to know if multiple gestations are identified

Screening, Education and Decision Assessment

Options counseling: adoption, abortion, parenting discussed

Assessment of Decision Making and Emotional Support

How is the client feeling about her decision?
Confident and clear about decision to have the abortion

Support System

- Client offered additional resources - Backline #
- Client informed about what to expect emotionally and physically before, during, and after procedure

Client Questions/Answers

Mena Maura (FULLY DEAF)
MRN:
08/02/2013 9:15 AM

Pertinent History

Planned/recent surgery requiring prolonged immobilization: no
Prior Rh status known: no

Birth Control

Current birth control method: None-pregnant
Desired birth control method: oral contraceptives
Patient reports no problems with current birth control method.

Allergies

No known allergies.

Pregnancy History

Total pregnancies: Gravida: 8.
Parity: 3. Spontaneous abortions: 1. Induced abortions: 3.
Currently pregnant: yes.
Not breastfeeding

Est Gest Age: 5 weeks 3 days based on LMP

Social History

New partner in last 90 days: no
History STIs: no

Substance Use:

Tobacco use: none.

IPV Screening

Denies coercion (including reproductive coercion)
Denies IPV

Patient states that the person who got her pregnant is aware she is here today for an abortion and he is supportive of her decision. Patient states she has someone who supports her decision. Patient denies being threatened by anyone if she does not do what they want with the pregnancy.

Reproductive Life Planning

Patient unsure of reproductive life plan

Objective

Vital Signs

<u>Time</u>	<u>BP</u>	<u>Ht In</u>	<u>Wt Lb</u>	<u>Temp F</u>	<u>Pulse</u>	<u>Resp</u>	<u>BMI</u>	<u>Rpt by Pt</u>
10:22 AM	120/60	61.00	150.00	96.4	88		28.34	no

<u>Pain Score</u>	<u>Bleeding</u>	<u>Loc</u>	<u>Comments</u>
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BMI Plan

Physical Exam

Not indicated

Mena Maura (FULLY DEAF)

MRN

08/02/2013 9:15 AM

Lab Study 1:15-cv-21017-XXXX
HEMOGLOBIN
Rh Factor

Results
13.3 gm/dL
Positive

Pelvic Ultrasound

<u>Order</u>	<u>Results</u>	<u>Comments</u>
Transvaginal Ultrasound	Probe: Transvaginal Ultrasound. Findings: yolk sac, gestational sac with double ring sign, single. Gestational age: 5 weeks 4 days.	

Exam satisfactory
Clinical Impression: Intrauterine Pregnancy

Fetus Measurements

<u>Date</u>	<u>Fetus</u>	<u>CRL</u>	<u>HC</u>	<u>BPD</u>	<u>FL</u>	<u>AC</u>	<u>Ht</u>	<u>Wd</u>	<u>Dp</u>	<u>GA Wks</u>	<u>GA Days</u>
08/02/2013							8	9	10	5	4

Assessment

Diagnosis Codes

Legally induced abortion (635)

Contraindication or special consideration: no
IUC not in place
Appropriate MAB candidate - Per Assessment
Patient states understands risks, benefits, and follow-up instructions

Pregnancy Test

Based on LMP gestation age is estimated at 5 weeks 3 days

Procedures

MAB

Patient desires medication abortion.

Plan

- Mifepristone administered to patient in clinic at 12:14 PM under observation

Birth Control Method at end of visit: Oral Contraceptives.

Meds Prescribed during this visit

<u>Drug Name</u>	<u>Dose</u>	<u>Qty</u>	<u>Sig</u>	<u>Refills</u>
Doxycycline Monohydrate	100 Mg	1	1tab po bid x 7d (#14)	0
Ibuprofen	800 Mg	1	1 tab PO q 4-6 hours PRN pain (#20)	0
Acetaminophen-codeine	300 Mg-30 Mg	1	1-2 po q 4-6 hours prn pain (#20)	0
Misoprostol	200 Mcg	1	4 tabs pb	0
Mifeprex	200 Mg	1	po administered to pt. in clinic	0
Promethazine Hcl	25 Mg	1	1 tab po 4-6 hours PRN nausea, (#10)	0

Education & Instructions

Risks, benefits and alternatives were discussed.

Mena-Mena (FULLY DEAF)

MR

08/02/2013 9:15 AM

Patient shown ultrasound, per patient request

Patient informed of US findings

Patient informed of eligibility for MAB or TAB

Patient has support at home including partner

Risk of anomalies and need to complete abortion discussed

After-hours/ER info given/reviewed

Post procedure instructions given.

Patient dispensed Misoprostol for at home administration on day 1

Mifepristone and Misoprostol explained/reviewed

Patient advised to contact clinic if little or no bleeding 24 hrs after Miso

Follow up plan: repeat ultrasound

BCM Counseling

Reviewed diagnosis(es) and plan with patient. Patient voiced understanding.

Comments

Pt is deaf, but understands lip reading. Wants IUD which she had before at end of this cycle

Provider:

Document generated by: FPA

Encounter location recorded at:

Jean Shehan

3119 SW 22nd Street

Unit A

Miami, FL 33145-3209

Proprietary and Confidential

Version 3.2.1.5 (5/6/7/9)

Mena, Maura (FULLY DEAF)

MRN:

08/02/2013 9:15 AM

MAURA MENA

MIFEPREX® (Mifepristone) Tablets, 200 mg

PATIENT AGREEMENT

Mifeprex* (mifepristone) Tablets

1. I have read the attached MEDICATION GUIDE for using Mifeprex and misoprostol to end my pregnancy.
2. I discussed the information with my health care provider (provider).
3. My provider answered all my questions and told me about the risks and benefits of using Mifeprex and misoprostol to end my pregnancy.
4. I believe I am no more than 49 days (7 weeks) pregnant.
5. I understand that I will take Mifeprex in my provider's office (Day 1).
6. I understand that I will take misoprostol in my provider's office two days after I take Mifeprex (Day 3).
7. My provider gave me advice on what to do if I develop heavy bleeding or need emergency care due to the treatment.
8. Bleeding and cramping do not mean that my pregnancy has ended. Therefore, I must return to my provider's office in about 2 weeks (about Day 14) after I take Mifeprex to be sure that my pregnancy has ended and that I am well.
9. I know that, in some cases, the treatment will not work. This happens in about 5 to 8 women out of 100 who use this treatment.
10. I understand that if my pregnancy continues after any part of the treatment, there is a chance that there may be birth defects. If my pregnancy continues after treatment with Mifeprex and misoprostol, I will talk with my provider about my choices, which may include a surgical procedure to end my pregnancy.
11. I understand that if the medicines I take do not end my pregnancy and I decide to have a surgical procedure to end my pregnancy, or if I need a surgical procedure to stop bleeding, my provider will do the procedure or refer me to another provider who will. I have that provider's name, address and phone number.
12. I have my provider's name, address and phone number and know that I can call if I have any questions or concerns.
13. 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.
14. I will do the following:
 - contact my provider right away if in the days after treatment I have a fever of 100.4°F or higher that lasts for more than 4 hours or severe abdominal pain.
 - contact my provider right away if I have heavy bleeding (soaking through two thick full-size sanitary pads per hour for two consecutive hours).
 - contact my provider right away if I have abdominal pain or discomfort, or I am 'feeling sick', including weakness, nausea, vomiting or diarrhea, more than 24 hours after taking misoprostol.
 - take the MEDICATION GUIDE with me when I visit an emergency room or a provider who did not give me Mifeprex, so that they will understand that I am having a medical abortion with Mifeprex.
 - return to my provider's office in 2 days (Day 3) to check if my pregnancy has ended. My provider will give me misoprostol if I am still pregnant.
 - return to my provider's office about 14 days after beginning treatment to be sure that my pregnancy has ended and that I am well.

Patient Signature: _____



Date: _____

8/2/2013

Patient Name (print): _____

Maura Mena

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 mifepristone.

Provider's Signature: _____

Date: _____

Name of Provider (print): _____

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. Give a copy of the MEDICATION GUIDE to the patient.

Rev 2:7/19/05

*Mifeprex is a registered trademark of Danco Laboratories, LLC

Accepted by _____

ID 08/16/2013 09:40:48 AM

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Department of Health AB Pamphlet Consent

I was provided with a copy of and given the opportunity to review the Florida Department of Health pamphlet entitled "Fetal Development and Alternatives to Terminating a Pregnancy" prior to providing my voluntary and informed written consent for a termination of pregnancy.



Name/Signature of Patient: Signed By: Maura (FULLY DEAF) Mc

Date: August 02, 2013

I specifically declined the opportunity to view the Department of Health pamphlet entitled "Fetal Development and Alternatives to Terminating a Pregnancy."

Name/Signature of Patient: {[NextGen Signature Field]}

Date: August 02, 2013

Name/Signature of Witness: {[NextGen Signature Field]}

Date: August 02, 2013

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Client Information for Informed Consent

USING THE ABORTION PILL

Before you have the abortion, you need to know the most common benefits, side effects, risks, and alternatives. We have listed them here for you. We are happy to answer any questions you have.

“Abortion pill” is a popular name for a medicine called mifepristone. (Mifeprex[®] is the brand name.) It ends the pregnancy. It does this by keeping your body from making a certain hormone called progesterone. The pregnancy cannot go on without progesterone.

After you take the abortion pill, you will take a second medicine called misoprostol. It opens the cervix and makes the uterus contract. This empties the uterus and completes the process. The whole process is called medication abortion.

There are different ways to take these medicines. There is the way approved by the FDA. The FDA way is talked about in the Medication Guide and Patient Agreement. You will read these papers. You will need to sign the Danco Patient Agreement to show that you understand the FDA way. Alternative ways to take the medicines have been studied. They are also safe and effective. By choosing one of the alternative ways, you will take the abortion pill (Mifeprex[®]) in the office. Then you take the misoprostol pills at home. We will give you instructions, “How to Take Your Pills.” It is important to follow these instructions. The amount and timing of the pills used is different from the FDA way.

Benefits

Using the abortion pill together with misoprostol is safe and effective. At Planned Parenthood, it has worked about 98 out of 100 times. Women can use it in the first nine weeks (63 days) of pregnancy.

- **Side-Effects.** They usually do not last long. They usually need little or no treatment.
- **Cramping is expected.** It will be most severe after you take the misoprostol. Milder cramps may last a day or two after that.
- **Bleeding is expected.** It will be heaviest soon after taking the misoprostol. You may bleed or spot for three to four weeks after the abortion. You can expect your next period in four to eight weeks.
- **Fever.** Having a temperature of 99- 100°F is okay. It should only last a short time.
- **Other.** It is common to have diarrhea, nausea, vomiting, headache, dizziness, back pain, and tiredness. They usually lighten up three days later. They usually stop within two weeks.

Emotional Reactions

A wide range of emotions is normal with abortion. Most women feel relief and do not regret their decision. Some women may feel sadness, guilt, and/or regret after an abortion, just as they may after giving birth. If you are not able to do your normal activities or are feeling bad after two weeks, call us. We can help or refer you to someone who can.

Risks

Using the abortion pill together with misoprostol is safe and effective. But there are risks with any medical procedure. Your risk depends on how healthy you are. If you are in poor health, your risk goes up. These are the possible risks of using this procedure:

- **Failure to end the pregnancy.** Sometimes the medicines do not end the pregnancy. But they may cause serious birth defects. You may need to take additional medicines or have an abortion in a clinic or a hospital if the pregnancy continues.
- **Incomplete abortion.** Sometimes some of the contents of the uterus are not emptied. This can cause too much bleeding, infection, or both. You may need an abortion in a clinic or a hospital if that happens. You may also need

other tests or treatments.

- 21017-XXXX Document 1-6 Entered on FLSD Docket 03/12/2015 Page 10 of 19
- **Blood clots in the uterus.** Clots in the uterus may cause cramping and pain. You may need a surgical procedure if that happens.
 - **Bleeding too much or too long.** To make it stop, you may need treatment. It might include medication or a suction procedure. In some cases, a blood transfusion is needed.
 - **Infection.** Most infections are easy to treat with medicine. But there is a small chance that you may need an abortion in a clinic, to go a hospital, or to have surgery.
 - **Allergic reaction.** Some women are allergic to the medicines that are used. Any medicine or drug can cause a serious reaction when used alone or with something else. It is important for you to let us know all the drugs that you are taking or that you are allergic to. This includes herbal drugs.
 - **Death.** Death from medication abortion is very rare. The risk of death from a full-term pregnancy and childbirth is much greater.

Call us right away if you have:

- **Abdominal pain.** This includes feeling sick, being weak, having nausea or diarrhea, or throwing up. It should not last longer than 24 hours after you take the second medicine. Call us right away if they do. Any one of them may be a sign of a serious infection. Or it could be another problem, like ectopic pregnancy. (That is a pregnancy that grows outside the womb.)
- **Heavy Bleeding.** Call us right away if you soak through two thick, full-size sanitary pads every hour for two hours in a row. Or call us if you think your bleeding is too heavy. One out of every 100 women bleed so much that that they need a surgical procedure to stop it.
- **Fever** Call us right away if you have a fever of 100.4°F or more if it lasts for four hours and it happens during the few days after you take the second pills. Fever that high can be a sign of serious infection. Or it could be another problem, like ectopic pregnancy.

We will give you instructions on how to take care of yourself during the abortion. We will give you a special telephone number to reach us if you have a problem. We will give you a time to return to Planned Parenthood for a follow-up visit.

The outcome of a medication abortion cannot be guaranteed. It is unlikely that you will need emergency medical care that cannot be provided at Planned Parenthood. If you do, however, you will be responsible for paying for it - even if Planned Parenthood refers you to another doctor or hospital because of a medical problem.

Options

There are two alternatives to abortion. They are parenthood and adoption. We can discuss any of these options with you. And we can help you with whatever decision you make.

There are alternatives to using the abortion pill. You can have the abortion done in a clinic. You can have it done in a hospital. Or you can go to another provider. You can have the abortion now or later in the pregnancy. But your risks get bigger the longer the abortion is delayed.

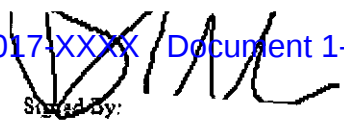
Your health is important to us. If you have any questions or concerns please call us at the nearest health center. We are happy to help you.



Signature of Patient: Signed By: Maura (FULLY DEAF) M.

Date: August 02, 2013

I witness that the client received this information, said she read and understood it, and had an opportunity to ask questions.

A handwritten signature in black ink, appearing to be 'D.M.L.', is written over the 'Signed By:' label.

Signature of Witness: Signed By:

Date: August 02, 2013

Planned Parenthood
of South Florida and the Treasure Coast, Inc.

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PAGER GUIDELINES

Planned Parenthood and its staff want you to have a speedy and complete recovery after your abortion. Sometimes during the recovery phase of abortion care, a patient may have questions, concerns, and / or problems which may require you to contact our office.

It is always in your best interest to contact the clinic where you received care at a time when it is open. Your record is there and the staff will have access to your information in order to answer your question or assess your concerns. Arrangements can be made to see you right away if necessary.

Sometimes there may be a problem that seems like an emergency when the clinic is closed. Planned Parenthood wants you to be able to contact a nurse at those times and so there is a nurse on call when the clinic is not open (including nights, weekends, and holidays). This person may be contacted by calling the beeper number:

1-888-962-2500

At the beep, enter your phone number.

- **ALWAYS include your area code or your call cannot be returned.**
- **Do NOT add any other numbers; just your area code and your number.**
- **It may take 30 minutes for the nurse to call you back. During that time:**
 - **Do not put your phone on voice mail.**
 - **Keep you phone line open (do not place another call or accept another call on that phone).**
 - **Take your temperature and record it -- the nurse will want that information.**
 - **Select a pharmacy that is near you (and OPEN at that time). Write the phone number down.**

Despite our best efforts to be available to you at all times, technology is not perfect. There may be times when your signal does not go through to the pager (stormy weather is often a cause). If you have not heard from the nurse in 30 minutes, place your call again. **If you do not receive a response and you think you are having an emergency (severe bleeding, high fever, severe pain -- unrelieved by the medications you have been instructed to take, or severe vomiting and/or diarrhea) immediately proceed to your nearest emergency room or call 911.** Your health and well-being are our foremost concerns.

I have read and understand this information. My questions have been answered and I have received a copy to take home with me.

Patient Signature: Signed By: Maura (FULLY DEAF) M

Date: August 02, 2013

Witness Signature: Signed By:

Date: August 02, 2013

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REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Patient #:

Name of Patient: Maura (FULLY DEAF) Mena

Date of Birth:

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.

I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthoods of South Florida and the Treasure Coast *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby request that a person authorized by PPSFTC provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

Please note that Planned Parenthood of South Florida and the Treasure Coast is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.



Patient Signature: Signed By: Laura (FULLY DEAF) M.

Date: August 02, 2013

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.



Witness Signature: Signed By:

Date: August 02, 2013

COMPLETE THIS SECTION IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN

Consenting Person Signature: {[NextGen Signature Field]}
Relationship to Patient:

Date: August 02, 2013

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Witness Signature: {[NextGen Signature Field]}

Date: August 02, 2013

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REQUEST FOR SURGERY OR SPECIAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Patient #:

Name of Patient: Maura (FULLY DEAF) Mena

Date of Birth:

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I will be given information about the test(s), treatments, service(s)/procedure(s)/ surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I was given *written patient information* and/or a copy of the Planned Parenthood Client Information for Informed Consent sheet. It was reviewed with me.

I understand that with any service/procedure/surgery, there is also the possibility of side effects. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorized Planned Parenthood staff to do whatever is necessary to preserve my health and welfare.

In the event I need more pain medication to safely continue or complete the procedure, I request and authorize Planned Parenthood staff to give me medications they believe necessary. This may include medications to reduce pain and/or anxiety. I understand every medication carries a small risk. I understand the clinician will only use medications if s/he believes it is clinically indicated.

I request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it) and perform the following service(s)/ procedure(s)/surgery:

(check all that apply)

In-Clinic Suction Abortion - Removal of uterine pregnancy less than 13 weeks gestational age by mechanical method.

In-Clinic Dilation & Evacuation (D&E) Abortion - Removal of uterine pregnancy at 13 weeks or greater gestational age by mechanical method.

Osmotic Dilator Insertion prior to Surgical Abortion - Short thin rods placed in the cervix (opening of uterus) to stretch the opening before the abortion procedure.

xx The Abortion Pill - Prescription medicine taken to stop pregnancy development and cause passage of uterine

Uterine Aspiration - Removal of blood or remaining pregnancy tissue from uterus following abortion.

Treatment of Miscarriage with a Suction Procedure - Removal of remaining pregnancy tissue from uterus following an early pregnancy loss.

Treatment of Miscarriage with Abortion Pill - Prescription medicine taken to cause passage of pregnancy tissue following an early pregnancy loss.

Colposcopy - Use of microscope to look for abnormal cells on cervix (opening of uterus).

Cervical Biopsy and Endocervical Sampling (ECS) - Removal of small piece(s) of tissue on cervix to check for abnormalities.

Endometrial Biopsy - Removal of cells from lining of uterus to check for abnormalities.

Vulvar Biopsy - Removal of small piece of tissue from the lips of vagina to check for abnormalities.

Cryotherapy of Cervix - Freezing of top layer of cervix (opening of uterus) to treat abnormal cells.

LEEP - A small electrical wire loop used to remove abnormal tissue from the cervix.

IUC Insertion- Placement of Mirena Paragard into uterus to prevent pregnancy.

Contraceptive Implant Insertion - After a shot of numbing medicine, birth control device (flexible 1 ½" rod) is placed under skin of upper arm to prevent pregnancy.

Contraceptive Implant Removal - After a shot of numbing medicine, small cut is made in skin and the birth control device is removed through it.

Hysteroscopic Tubal Sterilization (Essure®) - A method of permanent birth control. A tiny device, called a microinsert, is used to close the opening of each of the fallopian tubes (the tubes that carry the eggs from the ovaries to the uterus).

Cervical polyp removal - Removal of growth at opening of the uterus. The growth will be sent to the laboratory for testing.

Treatment of Bartholins Duct Abscess (I & D) - Small cut made to infected area to drain fluid from it.

Miminal Sedation - A medicine I will swallow to help me relax and be more comfortable.

Moderate Sedation - Medicine given into my vein to help me relax and be more comfortable.

Other:

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

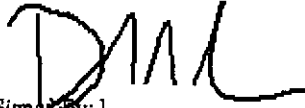
I understand that confidentiality will be maintained as described in PPSFTC *Notice of Health Information Privacy Practices* consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.



Name/Signature of Patient: Signed By: Maury (FULLY DEAF) M

Date: August 02, 2013

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.



Name/Signature of Witness: Signed By: J

Date: August 02, 2013

COMPLETE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN

Consenting Person Signature: {{NextGen Signature Field}}
Relationship to Patient:

Date: August 02, 2013

I witness the fact that the patient's legal guardian (or person consenting in her/his behalf) received the above mentioned information and said she/he read and understood same.

Witness Signature: {{NextGen Signature Field}}

Date: August 02, 2013

Indian River 3106 20th St - Vero Beach 772.778.0037 | Martin County 1322 NW Federal Hwy - Stuart 772.692.2023
West Palm Beach 931 Village Blvd, Suite 904 - WPB 561.683.0302 | Boca Raton 8177 Glades Rd, Bay 25 - Boca Raton 561.226.4116
Wellington 10111 Forest Hill Blvd, #304 - Wellington 561.296.4919 | Pembroke Pines 263 N University Dr - Pembroke Pines 954.989.5747
Miami Jean Shehan Center 3119A Coral Way - Miami 305.285.5535 | Kendall 11440 SW 86th St, #109 - Miami 786.263.0001

Client Information for Informed Consent

ULTRASOUND CONSENT PRIOR TO ABORTION

This form documents the ultrasound consent requirements prior to termination of pregnancy of Florida State Statute 390.0111.

The person who performed the ultrasound offered the patient the opportunity to view the live ultrasound images and hear an explanation of them.

I was offered an opportunity to view the live ultrasound images and hear an explanation of them. I **declined** this opportunity. My decision not to view the live images or hear an explanation was not based on any undue influence from any person. I was not discouraged by anyone from viewing the ultrasound images and hearing an explanation of them. I made this decision of my own free will prior to completing the informed consent for an abortion.

Patient Signature: {[NextGen Signature Field]} Date: August 02, 2013

Staff Signature: {[NextGen Signature Field]} Date: August 02, 2013

I was offered an opportunity to view the live ultrasound images and hear an explanation of them. I **accepted** this offer.

Patient Signature: Signed By: Maura (FULLY DEAF) M. Date: August 02, 2013

Staff Signature: Signed By: _____ ine A Date: August 02, 2013

At the patient's request, I explained the ultrasound images while she viewed the live ultrasound images. This was done prior to signing the consents for an abortion.

Signature and Credentials

of Staff Explaining US: Signed By: Maura (FULLY DEAF) M. Date: August 02, 2013

Patient Signature: Signed By: _____ Date: August 02, 2013

Unless requested by the woman, the person performing the ultrasound may **not** offer the opportunity to view the images and hear the explanation and the explanation may **not** be given if, at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a restraining order, police report, medical record, or other court order or documentation is presented which provides evidence that the woman is obtaining the abortion because the woman is a victim of rape, incest, domestic violence, or human trafficking or that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible impairment of a major bodily function if the woman delayed terminating her pregnancy.

I did not offer the patient the opportunity to view the ultrasound images and hear the explanation as allowed in Florida State Statute 390.0111. A copy of the documentation provided is attached.

Staff Signature: {{NextGen Signature Field}}

Date: August 02, 2013

Although appropriate documentation was provided and I did not offer the opportunity to view the ultrasound, the patient requested to view the ultrasound images and hear an explanation. She was shown the live ultrasound images and heard an explanation.

Signature of Staff

Performing US: {{NextGen Signature Field}}

Date: August 02, 2013