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OBSTETRICS • GYNECOLOGY • INFERTILITY

CIRCUMCISIONS

All circumcisions will be performed prior to you being discharged from the hospital, provided there are no medical problems and the clearance from the pediatrician is obtained.

If you are a self-pay patient or have Medicaid coverage you are required to make financial arrangements with our office prior to delivery. Circumcisions are not a covered benefit with Medicaid. The price is $350.00.

Thank you for your attention in this matter.

Patient Name	Witness
Signature	Date

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Genetic Testing

AFP – Plus is maternal serum (blood) screen for birth defects. The AFP – Plus testing incorporates the features of AFP screening but detects three times as many cases of Down Syndrome as AFP testing alone.

AFP – Plus is a combination of three maternal serum (blood) testing; alpha fetoprotein (AFP), unconjugated estriol (uEST), and human chorionic gonadotrophin (HCG). The AFP – Plus screening procedure is based on studies showing that pregnancies affected with Down Syndrome have lower serum levels of AFP and uEST and higher levels of HCG than women with unaffected pregnancies.

AFP – Plus testing detects approximately 85% of open neural tube defects and approximately 60-70% of Down Syndrome pregnancies. AFP – Plus does not reliably screen for other chromosomal abnormalities.

AFP – Plus is a screening test. A normal result does NOT guarantee a normal baby. Should the AFP – Plus results be abnormal, additional diagnostic test or procedures may be recommended.

I have read the above and understand that benefits of AFP – Plus screening.

I request the following testing:

☐ AFP – Plus

☐ I decline any testing

_____ _____

Patient Signature Date

_____ _____

Witness Date

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VICTOR H. CANTERO, M.D., LLC.
Victor H. Cantero, M.D., F.A.C.O.G.
OBSTETRICS • GYNECOLOGY • INFERTILITY

HARMONY CONSENT FORM

Harmony Prenatal Test is a new type of test that analyzes DNA in a sample of your blood to predict the risk of Down syndrome (trisomy 21) and certain other genetic conditions.

Harmony Prenatal Test requires a single blood draw. It can be done as early as 10 weeks or later in pregnancy.

Other commonly used tests for Down syndrome are performed later in pregnancy and may require multiple office visits.

The Harmony Prenatal Test is a screening test that is more accurate than traditional Down syndrome blood tests.[1] The Harmony test is much less likely to give a false-positive result compared to traditional tests such as the first trimester screening test.[1] That means there will be much less chance your doctor would recommend follow-up diagnostic testing, such as amniocentesis.[2]

Harmony also tests for two other genetic conditions, trisomy 18 (Edward syndrome) and trisomy 13 (Patau syndrome).

In addition, with Harmony you have the option to evaluate fetal sex, X and Y sex chromosomes.

Non-invasive prenatal testing based on cell-free DNA analysis is not considered diagnostic. Once you have your Harmony test results, you can discuss your pregnancy care with your healthcare provider.

FINANCIAL RESPONSIBILITY

Harmony is covered by many insurance plans. While the exact cost depends on your insurance coverage, Harmony provides insured parents with a program that allows them to pay no more than a maximum out-of-pocket. If you do not have health insurance, or have financial need, there are additional Harmony programs in the US that can assist with test costs.

Call 855-927-4672 for help with billing or payment questions.

I hereby understand and authorize the office of my physician Victor H. Cantero, MD to submit my blood collection for the Harmony test and understand that I must contact Ariosa Lab to determine the financial cost of such test. I understand that in the event that my insurance carrier denies payment for the services I will be fully responsible for any fees associated with such test. Our office will not provide any medical necessity documentation to your insurance carrier for optional testing.

VICTOR H. CANTERO, M.D., LLC.

Victor H. Cantero, M.D., F.A.C.O.G.

OBSTETRICS ◦ GYNECOLOGY ◦ INFERTILITY

PATIENT CONSENT STATEMENT

I have read or have had read to me the above informed consent information about the Harmony. I have had the opportunity to ask questions of my health care provider regarding this test, including the reliability of test results, the risks, and the alternatives prior to giving my informed consent. I understand that my personal health information and my blood samples will be sent to Ariosa Diagnostics. I request and authorize Ariosa Diagnostics Lab to test my sample(s) for the chromosome conditions listed above. I acknowledge that Ariosa Diagnostics will send the results to my ordering healthcare provider. In the event of a high risk result, I acknowledge that Ariosa Diagnostic may contact my healthcare provider to obtain follow-up diagnostic information to ensure quality and accuracy in reporting. I acknowledge that I must sign the consent statement located on the test requisition form that will be sent with my sample(s) to Ariosa Diagnostics understand that I must also sign this consent form which will remain in my electronic medical chart.

Patient Signature:_____ Date:_____

Printed Name:_____ DOB:_____

Witness/MD Signature:_____

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VICTOR H. CANTERO, M.D., LLC.
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CONSENT CARRIER TESTING FRAGILE X SYNDROME

The most common inherited cause of mental retardation is Fragile X syndrome. Symptoms involve developmental delay, mental retardation, autism and hyperactivity. Women who are carriers are at risk to have a child with mental retardation. Fragile X syndrome affects primarily boys and approximately 1 in 260 women. It can also occur in all ethnicities.

Inheritance
If the mother is a carrier, there is a 50% chance the child will have Fragile X syndrome.

Consent
If I am a carrier, prenatal testing is available to find out whether or not the baby has inherited the abnormal Fragile X gene.

Referral
We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause Fragile X syndrome.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

☐ **I want** Fragile X carrier testing ☐ **I do not want** Fragile X carrier testing

Patient Signature _____ Date _____

Witness _____ Date _____

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VICTOR H. CANTERO, M.D., LLC.
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CONSENT CARRIER TESTING SPINAL MUSCULAR ATROPHY

Spinal Muscular Atrophy (SMA) is the most common inherited cause of early childhood death. It affects 1 in 35 to 1 in 117 people in the U.S. and varies by ethnicity. SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling head or neck movements, crawling and walking. The most common form affects infants in the first month of life and can cause death between 2-4 years of age. Less commonly the condition starts later and people can survive into adulthood. SMA does not affect the learning process and there is no cure or treatment.

Inheritance
If the test shows you are a carrier of SMA, the next step is for your partner to have carrier testing performed. Both parents must be carriers for the baby to be at risk for SMA. If your partner has a negative test result and no family history of SMA the chance of your baby having SMA is less than 1%. If both parents are carriers, there is 25% or a chance of 1 in 4 to have a child with SMA.

Referral
We will arrange a consult with a perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause SMA.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

☐ I want SMA carrier testing ☐ I do not want SMA carrier testing

Patient Signature _____ Date _____

Witness _____ Date _____

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VICTOR H. CANTERO, M.D., LLC.
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PROCEDURE: CESAREAN SECTION

Your doctor has determined that it will be necessary to deliver your baby by Cesarean section or "C-section." This is a major operation involving a surgical cut through the abdominal or "belly" wall and through the wall of the "womb." Complications from this type of delivery are uncommon, but they do occur. Therefore, your doctor makes no guarantee as to the possible result obtained from method of delivery.

As with a surgical procedure, bleeding and infection are possible complications of C-section. These complications can result in prolonged illness, permanent deformity, poorly healing wounds, the need for blood transfusions, and the need for further major surgery. On rare occasions, it is necessary for the doctor to remove the womb during C-section to stop bleeding. Damage to the urinary system and the intestines are also rare complications of C-sections. This type of damage can result in malfunction of the intestines and the female organs. A hernia or "rupture" developing at the site of the surgical cut in the belly is another uncommon complication of this operation. Because there will be a scar in the womb, the chance of rupturing during future pregnancy is higher.

Some of the complications of C-section may require further surgery; some may cause permanent deformity; some can result in sterility or the permanent inability to become pregnant; rarely some can even be fatal. However, many of the above complications are also associated with vaginal deliveries. Therefore, in those patients in whom C-section is indicated the procedure may provide the patient with the best chance of success and the lowest risk of complications.

ADDITIONAL RISKS AND ALTERNATIVES: _____

(To be filled in hero and on reverse side by doctor as necessary): _____

I CERTIFY: I have read or had read to me the contents of this form; I understand the risks and alternatives involved in this procedure; I have had the opportunity to ask any questions which I had and all of my questions have been answered.

DATE: _____ TIME: _____ SIGNED: _____
(Signed by the person legally authorized to consent for patient)

WITNESS: _____

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HIV TEST IN PREGNANCY CONSENT FORM

Information is provided in accordance to Florida Law

HIV/AIDS is an important health concern for pregnant women because she can pass the HIV virus to her baby during pregnancy or childbirth or through breastfeeding. HIV testing is recommended as a routine test for all pregnant women. It is much better for a woman to know her HIV status as early in pregnancy as possible so she can make important decisions about health care and breast feeding. Tests are available to detect antibodies for HIV that are safe and can be done along with other prenatal blood tests.

A positive test does not necessarily mean that you have AIDS or that you will become ill with AIDS. A positive test does mean that can infect others with the virus and that you must take precautions to prevent spreading the infection. If your test is positive, you will again knowledge and understanding of an important medical condition and be able to inform your sexual partner (s) and health care provider (s).

There are medications that may help a woman who is pregnant and has HIV to reduce the chance of passing HIV to her baby. If a pregnant women is HIV-positive and does not get treatment, her baby has about a 25% chance of getting HIV from her. But if an HIV-positive pregnant woman receives appropriate medication as late as during the delivery of her child, she can reduce the risk of transmission by at least 50%.

A negative test result may mean that you have not been infected with HIV-1. If you have been engaging in behaviors that put you at risk, you may want to be retested in approximately six months. A negative test may also mean that your body has not had time to develop antibodies to HIV-1 and that you have an early infection.

Because treatment is so effective in preventing babies from getting HIV, Florida law and regulations require that every pregnant women be counseled about HIV and the benefits of testing and be offered and HIV test along with the standard blood test for syphilis and hepatitis B surface antigen (HBsAg). Testing must be offered at the time of the first examination relating to the current pregnancy and again at 28 to 32 weeks gestation.

Although HIV testing is routinely performed as part of the antenatal testing protocol, you have the right to refuse the test. The decision to have testing for syphilis, hepatitis B, or HIV is voluntary and you may withdraw your consent at any time.

Your physician will answer any questions you may have about HIV testing. If you are pregnant and you test positive for HIV, your physician can provide the care you need and information about services and options available to you. Your physician can tell you the risk of passing HIV infection to your baby, about medications given during pregnancy that can significantly reduce the risk of passing HIV to your baby, and the medical care available for babies who may be infected with HIV.

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CONSENT TO HIV-1 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the rules have been explained to me. I understand that if the results indicate that if the results indicate that my blood contains antibody to HIV, it means that I may have been infected with the HIV virus, which is believed to cause AIDs (Acquired Immune Deficiency Syndrome).

AT FIRST PRENATAL VISIT

☐ I authorize my healthcare providers to collect one or more blood specimen form me at the time of my first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV- 1 (human immunodeficiency virus). This is the virus which has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report test results to me in person and not by telephone or by mail. At that time, I will have the opportunity to receive counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of, exposure to, and transmission of HIV has been made available to me.

Consent to Release

I understand that the test results will be confidential and will not be disclosed to any person without my consent unless permitted or required by law, I also consent to the release of the test results to _____

☐ REFUSAL OF HIV-1 ANTIBODY TESTING

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered and with full knowledge of the consequences, I refuse to give my consent for HIV testing.

_____ _____

Patient Signature Date/Time

_____ _____

Witness Name of Patient (Please Print)

IN THIRD TRIMESTER

☐ Authorization For Repeat HIV Testing In Third Trimester Of Pregnancy

I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the retest is performed and will provide me with the test results.

☐ I Decline Repeat HIV Testing In Third Trimester of Pregnancy

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered and with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

_____ _____

Patient Signature Date/Time

_____ _____

Witness Name of Patient (Please Print)

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CONSENT TO CARRIER TESTING CYSTIC FIBROSIS

Cystic Fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. Symptoms of CF vary but include lung congestion, pneumonia, diarrhea, and poor growth. Most people with CF have severe medical problems and some die at a young age. Others experience few symptoms and may be unaware of having CF. there is no cure for CF at this time and it does not affect the learning process in children. Many people with CF have died at a very young age in the past. As a result of scientific advantages these days many with the disease are living into their 20's and 30's.

WHAT ARE THE CHANCES OF MY BABY HAVING CYSTIC FIBROSIS?

You can have a child with CF even if there is no family history. Carrier frequency in the U.S. is 1 in 30 on average and varies by ethnicity. CF testing can help determine if you are a carrier and at risk to have two altered genes. Most people have two normal copies of the CF gene.

You should be certain you understand the following:

- The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause CF.
- The tests do not detect all carriers of the disease.
- The laboratory needs accurate information about my family history for the most accurate interpretation of the test results.
- The decision to have the carrier testing is completely mine.
- No other tests will be performed or reported on my sample unless authorized by my doctor. Any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

☐ **I want** CF carrier testing ☐ **I do not want** CF carrier testing

_____ _____
Patient Signature Date

_____ _____
Witness Date

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Cord Blood Stem Cell Preservation

Frequently Asked Questions

1. **What is cord blood?** Cord blood is the blood remaining in your child's umbilical cord following birth. It is a rich, non-controversial source of stem cells that must be collected at the time of birth.

2. **What are stem cells?** Stem cells are the building blocks of our blood and immune systems. They are found throughout the body including bone marrow, cord blood and peripheral blood. They are particularly powerful because they have the ability to treat, repair and/or replace damaged cells in the body.

3. **Why do families choose to bank their newborn's stem cells?** Today, cord blood stem cells have been used in the treatment of approximately 80 diseases.[1*] Banking your baby's stem cells guarantees the cells will be available to your family should you need to use them. Cord blood is also being used in emerging treatments, for diseases like Type 1 Diabetes[2] and Cerebral Palsy,[3] which require a child's own cord blood. Stem cells from a related source are the preferred option for all treatments, and transplants using cord blood from a family member are more likely to be successful than transplants using cord blood from a non-relative (i.e., a public source).[4]

4. **How is cord blood collected?** The collection process is safe, easy and painless for both mother and baby and does not interfere with the delivery. After the baby is born, but before the placenta is delivered, a medical professional will clean a 4 to 8 inch area of the umbilical cord with antiseptic solution and insert a needle connected to a blood bag into the umbilical vein. The blood flows into the bag by gravity until the umbilical vein is emptied. The blood bag is clamped, sealed, labeled and shipped by courier to a processing lab. The collection itself typically takes about 2 to 4 minutes.

5. **Who can use my newborn's stem cells?** Your newborn's stem cells have the potential to be used by the child, and, if there's an adequate match, by siblings and sometimes parents. An adequate match using related cord blood is defined as a 3 of 6 HLA Match. When two people share the same HLAs, they are said to be a 'match' which means their tissues are immunologically compatible. Your newborn's cord blood will always be a 100% match for him or herself and there is up to a 75% probability of a match for a sibling.[5]

Options for Cord Blood & Cord Tissue Banking:

Expecting a child is exciting for both new and experienced parents. You have many important decisions to make for your family's future, including choosing a cord blood and cord tissue banking option that's right for you. *(Check one below)*:

☐ **Family Banking**

Family banking allows families to save their child's cord blood and cord tissue exclusively for their family's use. This service is available through private cord blood banks that charge a fee to collect, process, freeze and store your child's stem cell-rich umbilical cord blood and tissue for your family's future medical use. Contact a family bank to enroll in this service.

☐ **Donation**

Cord blood donation is a way for you to preserve the potentially life-saving stem cells found in the blood of your child's umbilical cord in a donation facility for the public good. Once you donate the cord blood to a public facility, your family does not retain ownership of the cord blood. Find out if your hospital accepts cord blood donations. (Cord tissue cannot be donated.)

☐ **Discard**

Discard umbilical cord blood and tissue as waste. The cells cannot be retrieved for future use.

I have read the information above and discussed my cord blood and tissue banking options with my healthcare provider. I have indicated my choice above.

Patient Signature _____ Date _____

For Medical Professional's Use Only

Patient Name: DOB:

Medical Professional: Cord Blood Bank:

There is no guarantee that banked cord blood or tissue will be a match for a family member or will be an appropriate or effective treatment. Autologous cord blood and cord tissue stem cells will not guarantee suitable treatment for all inherited genetic diseases.

Florida's Healthy Start

What is Healthy Start?

- A voluntary program that provides support services to pregnant women and infants in Florida to improve pregnancy, health and developmental outcomes, increase access to health care, reduce low birth weight and preterm birth, and reduce infant mortality and morbidity.

Why should every pregnant woman in Florida receive a Healthy Start Screen?

- Florida statute requires Healthy Start risk screening to be offered to every pregnant woman and newborn infant in Florida. The prenatal risk screen is designed to identify pregnant women who may experience preterm delivery or deliver a low birth weight baby. The infant risk screen is designed to identify babies who may experience poor health and developmental outcomes or death in their first year of life.
- Saying "yes" to the screen will assist in gathering information that can improve health care for all of Florida's moms and babies.
- The answers to all questions on the screening form are strictly confidential.
- There is no cost for the Healthy Start Prenatal and Infant risk screens or program services.

What services does Healthy Start provide?

- Care coordination, home visiting, and outreach to help assure access to health care and other community resources.
- Support to families in reducing identified risk factors.
- Additional services may include breastfeeding education and support, childbirth education and support, parenting support, smoking cessation, nutritional counseling, psychosocial counseling, and other risk appropriate care.

Healthy Families Florida

What is Healthy Families Florida?

- A voluntary, community-based home visiting program that helps parents gain skills and knowledge to help their children grow up healthy, safe, nurtured, and ready to succeed in school. The program also helps families gain self-sufficiency and access health care and other support services they may need. Services are provided at no cost to the families.

Who is eligible for Healthy Families Florida?

- Healthy Families Florida offers home visiting services to families who live in the service area and who are experiencing stressful life situations. Well-trained family support workers begin providing home visits during pregnancy or within the first three months of the child's birth. Services can continue for up to five years, depending on the needs of the family.

What services does Healthy Families Florida provide?

During home visits, family support workers:

- Help parents understand their child's capabilities at each developmental stage and teach them positive forms of discipline.
- Help parents develop a strong parent-child relationship and model experiences and activities that stimulate healthy brain development.
- Provide early developmental screenings and referrals to appropriate services as needed.
- Assist parents in conducting home safety checks to make sure the home is safe for children.
- Teach problem solving skills and healthy ways of coping with the everyday stress of raising a child.
- Connect families with medical providers and other community services as needed.
- Encourage parents to set and achieve goals for themselves and their families.

VICTOR H. CANTERO, M.D., LLC.

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PROGENITY CONSENT FORM

Progenity Inc. Prenatal Test is a new type of test that analyzes DNA in a sample of your blood to predict the risk of Down syndrome (trisomy 21) and certain other genetic conditions.

Progenity Inc. Prenatal Test requires a single blood draw. It can be done as early as 10 weeks or later in pregnancy.

Other commonly used tests for Down syndrome are performed later in pregnancy and may require multiple office visits.

The Progenity Inc. Prenatal Test is a screening test that is more accurate than traditional Down syndrome blood tests.[1] The Progenity Inc. test is much less likely to give a false-positive result compared to traditional tests such as the first trimester screening test.[1] That means there will be much less chance your doctor would recommend follow-up diagnostic testing, such as amniocentesis.[2]

Progenity Inc. also tests for two other genetic conditions, trisomy 18 (Edward syndrome) and trisomy 13 (Patau syndrome).

In addition, with Progenity Inc. you have the option to evaluate fetal sex, X and Y sex chromosomes.

Non-invasive prenatal testing based on cell-free DNA analysis is not considered diagnostic. Once you have your Progenity Inc. test results, you can discuss your pregnancy care with your healthcare provider.

FINANCIAL RESPONSIBILITY

Progenity Inc. is covered by many insurance plans. While the exact cost depends on your insurance coverage, Progenity Inc. provides insured parents with a program that allows them to pay no more than a maximum out-of-pocket. If you do not have health insurance, or have financial need, there are additional Progenity Inc. programs in the US that can assist with test costs.

Call 1-855-293-2639 for help with billing or payment questions.

CPT: 81507 (NIPT) ,81599 (Fetal Sex)

Self- Pay Price: $549.00 Innatal (Trisotomy 13, 18, 21 & Fetal Sex)

$349.00 Trio (CF, SMA and FragileX)

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VICTOR H. CANTERO, M.D., LLC.

$599.00 Standard (Screens 29 Disorders)

Victor H. Cantero, M.D., F.A.C.O.G.

I hereby understand and authorize the office of my physician Victor H. Cantero, MD to submit my blood collection for the Progenity Inc. test and understand that I must contact Progenity Inc. to determine the financial cost of such test. I understand that in the event that my insurance carrier denies payment for the services I will be fully responsible for any fees associated with such test. Our office will not provide any medical necessity documentation to your insurance carrier for optional testing.

PATIENT CONSENT STATEMENT

I have read or have had read to me the above informed consent information about the Progenity Inc. I have had the opportunity to ask questions of my health care provider regarding this test, including the reliability of test results, the risks, and the alternatives prior to giving my informed consent. I understand that my personal health information and my blood samples will be sent to Progenity Inc. I request and authorize Progenity Inc. to test my sample(s) for the chromosome conditions listed above. I acknowledge that Progenity Inc. will send the results to my ordering healthcare provider. In the event of a high risk result, I acknowledge that Progenity Inc. may contact my healthcare provider to obtain follow-up diagnostic information to ensure quality and accuracy in reporting. I acknowledge that I must sign the consent statement located on the test requisition form that will be sent with my sample(s) to Progenity Inc. understand that I must also sign this consent form which will remain in my electronic medical chart.

Patient Signature:_____Date:_____

Printed Name:_____DOB:_____

Witness/MD Signature:_____

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