Patient Addressograph

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Date: – – ID #:

ANTEPARTUM RECORD

Hospital of Delivery:

Name:
LAST FIRST MIDDLE

Newborn Care Provider:	Referred By:
Primary Care Provider/Group:	Address:
Final EDD:	
Birth Date: – – Age: Race: Marital Status: S M W D Sep	Address:
	Zip: Phone: (1) (2)
Occupation: Education: (Last Grade Completed)	E-Mail:
Language: Ethnicity:	Insurance Carrier/Medicaid #:
Partner: Phone:	Policy #:
Father Of Baby: Phone:	Emergency Contact: Phone:

Total Preg:	Full Term:	Premature:	Ab, Induced:	Ab, Spontaneous:	Ectopic Pregnancy:	Multiple Births:	Living:

Menstrual History

Lmp ☐ Definite ☐ Approximate (Month Known) ☐ Unknown ☐ Normal Amount/Duration ☐ Final: _____

Duration: Q _____ Days

Prior Menses: _____ Date

Frequency: Q _____ Days

Contraception at pregnancy ☐ Yes ☐ No

Menarche: _____ (Age Onset)

Hcg + ___/___/___

Past Pregnancies (Last Five)

Date Month/ Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/ Complications

Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment
A. Drug/Latex Allergies/ Reactions	☐	☐	
B. Allergies (Food, Seasonal, Environmental)	☐	☐	
1. Neurologic/Epilepsy	☐	☐	
2. Thyroid Dysfunction	☐	☐	
3. Breast Disease/Breast Surgery	☐	☐	
4. Pulmonary (TB, Asthma)	☐	☐	
5. Heart Disease	☐	☐	
6. Hypertension	☐	☐	
7. Cancer	☐	☐	
8. Hematologic Disorders	☐	☐	
9. Anemia	☐	☐	
10. Gastrointestinal Disorders	☐	☐	
11. Hepatitis/Liver Disease	☐	☐	
12. Kidney Disease/UTI	☐	☐	
13. Deep Vein Thrombosis	☐	☐	
14. Diabetes (Type 1 Or Type 2)	☐	☐	
15. Gestational Diabetes	☐	☐	
16. Autoimmune Disorders	☐	☐	
17. Dermatologic Disorders	☐	☐	
18. Operations/Hospitalizations (Year & Reason)	☐	☐	
19. Gyn Surgery (Year & Reason)	☐	☐	
20. Anesthetic Complications	☐	☐	
21. History Of Blood Transfusions	☐	☐	
22. Infertility	☐	☐	
23. Art (IVF Or FET)	☐	☐	
24. History of Abnormal Pap	☐	☐	
25. History of STI	☐	☐	
26. Psychiatric Illness	☐	☐	
27. Depression/Postpartum Depression	☐	☐	
28. Trauma/Violence	☐	☐	
29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)	☐	☐	
30. Alcohol (AMT/Wk)	☐	☐	
31. Drug Use (Including Opioids) (Uses/Wk)	☐	☐	
32. Polycystic Ovary Syndrome	☐	☐	
33. Other	☐	☐	

Prepreg	Preg	# Years Use

*P= Personal, F= Family

COMMENTS: _____

Patient Name:		Birth Date: – –	ID No.:	Date: – –

Genetic Screening*

Condition	Patient	Partner	Other	Relationship
Congenital Heart Defect				
Neural Tube Defect				
Hemoglobinopathy Or Carrier				
Cystic Fibrosis				
Chromosome Abnormality				
Tay–Sachs				
Hemophilia				
Intellectual Disability/Autism				
Recurrent Pregnancy Loss/Stillbirth				
Other Structural Birth Defect				
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)				

Teratogen Exposures Since LMP/Pregnancy

	Yes	No	Details/Date
Prescription Medications			
Over The Counter Medications			
Alcohol			
Illicit Drugs			
Maternal Diabetes			HGB A1C
Other			
Uterine Anomaly/DES			

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

Infection History

	Yes	No
1. Live with Someone with TB or Exposed to TB		
2. Patient or Partner Has History of Genital Herpes		
3. Rash or Viral Illness Since Last Menstrual Period		
4. Prior GBS-Infected Child		
5. History of STIs: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID		

	Yes	No
6. HIV Infection		
7. History Of Hepatitis		
8. Recent Travel History or Partner Travel Outside of Country		
9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.		
10. Other (See Comments)		

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible)			
Influenza† (Each pregnancy as soon as vaccine is available)			
Varicella†			
MMR (Rubella-containing vaccine)†			
HPV			

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Hepatitis A (When Indicated)			
Hepatitis B (When Indicated)			
Meningococcal (When Indicated)			
Pneumococcal (When Indicated)			

*Yes/No and date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Initial Physical Examination

Date: _____ / _____ / _____ BP/Prepregnancy Weight: _____ Height: _____ BMI: _____

1. Heent	☐	Normal	☐	Abnormal	11. Vulva	☐	Normal	☐	Condyloma	☐ Lesions
2. Teeth	☐	Normal	☐	Abnormal	12. Vagina	☐	Normal	☐	Inflammation	☐ Discharge
3. Thyroid	☐	Normal	☐	Abnormal	13. Cervix	☐	Normal	☐	Inflammation	☐ Lesions
4. Breasts	☐	Normal	☐	Abnormal	14. Uterus Size		Weeks			☐ Fibroids
5. Lungs	☐	Normal	☐	Abnormal	15. Adnexa	☐	Normal	☐	Mass	
6. Heart	☐	Normal	☐	Abnormal	16. Rectum	☐	Normal	☐	Abnormal	
7. Abdomen	☐	Normal	☐	Abnormal	17. Clinical Pelvimetry	☐	Concerns	☐	No Concerns	
8. Extremities	☐	Normal	☐	Abnormal						
9. Skin	☐	Normal	☐	Abnormal						
10. Lymph Nodes	☐	Normal	☐	Abnormal						

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____

If you would like more information or would like to receive a copy of Section 766.301-766.316, Florida Statutes, which detail the provisions of the NICA Plan, please call or write:

Florida Birth-Related Neurological Injury Compensation Association
Post Office Box 14567
Tallahassee, Florida 32317-4567
Telephone: (850) 488-8191
Toll Free: 1-800-398-2129
www.nica.com

Section 766.301-766.316, Florida Statutes, ("NICA law") provides rights and remedies for certain birth-related neurological injuries and is an exclusive remedy. This brochure is prepared in accordance with the mandate of Section 766.316, Florida Statutes. A copy of the complete statute is available free of charge to completely inform patients of their rights and limitations under the application provisions of Florida law. Since 1989, numerous court cases have interpreted the NICA law, clarifying legislative intent.

Florida Birth-Related Neurological Injury Compensation Association

Peace of Mind
For An Unexpected Problem

The birth of a baby is an exciting and happy time. You have every reason to expect that the birth will be normal and that both mother and child will go home healthy and happy.

Unfortunately, despite the skill and dedication of doctors and hospitals, complications during birth sometimes occur. Perhaps the worst complication is one which results in damage to the newborn's nervous system – called a "neurological injury". Such an injury may be catastrophic, physically, financially and emotionally.

In an effort to deal with this serious problem, the Florida Legislature, in 1988, passed a law which created a Plan that offers an alternative to lengthy malpractice litigation processes brought about when a child suffers a qualifying neurological injury at birth. The law created the Florida Birth-Related Neurological Injury Compensation Association (NICA).

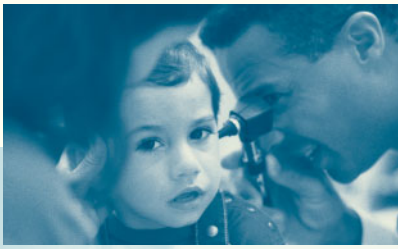
Exclusive Remedy

The law provides that awards under the Plan are exclusive. This means that if an injury is covered by the Plan, the child and its family are not entitled to compensation through malpractice lawsuits.

Criteria and Coverage

Birth-related neurological injuries have been defined as an injury to the spinal cord or brain of a live-born infant weighing at least 2500 grams at birth. In the case of multiple gestation, the live birth weight is 2000 grams for each infant. The injury must have been caused by oxygen deprivation or mechanical injury, which occurred in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital. Only hospital births are covered.

The injury must have rendered the infant permanently and substantially mentally and physically impaired. The legislation does not apply to genetic or congenital abnormalities. Only injuries to infants delivered by participating physicians, as defined in s. 766.302(7), Florida Statutes, are covered by the Plan.



Compensation

Compensation may be provided for the following:

- Actual expenses for necessary and reasonable care, services, drugs, equipment, facilities and travel, excluding expenses that can be compensated by state or federal government or by private insurers.
- In addition, an award, not to exceed $100,000 to the infant's parents or guardians.
- Death benefit in the amount of $10,000.
- Reasonable expenses for filing the claim, including attorney's fees.

NICA is one of only two (2) such programs in the nation, and is devoted to managing a fund that provides compensation to parents whose child may suffer a qualifying birth-related neurological injury. The Plan takes the "No-Fault" approach for all parties involved. This means that no costly litigation is required and the parents of a child qualifying under the law who file a claim with the Division of Administrative Hearings may have all actual expenses for medical and hospital care paid by the Plan.

You are eligible for this protection if your doctor is a participating physician in the NICA Plan. If your doctor is a participating physician, that means that your doctor has purchased this benefit for you in the event that your child should suffer a birth-related neurological injury, which qualifies under the law. If your health care provider has provided you with a copy of this informational form, your health care provider is placing you on notice that one or more physician(s) at your health care provider participates in the NICA Plan.

ADVANCED OBGYN INSTITUTE

INFORMED CONSENT OF MY PHYSICIAN PARTICIPATION IN THE

FLORIDA BIRTH RELATED NEUROLOGICAL INJURY ASSOCIATION (NICA)

I hereby acknowledge that:

1. I have been advised that Advanced OBGYN Institute is participating in the NICA Plan;
2. I have been furnished with a copy of the NICA brochure which describes the NICA plan and my rights and limitations under the NICA Plan;
3. I understand that the no-fault aspects of the NICA Plan will serve as exclusive remedy for injury which qualifies under the NICA Plan and that as a result I am forfeiting any and all rights to bring legal action in a Court of Law for damage in connection with such injuries;
4. Any questions I may have had regarding my physician's participation in the NICA Plan and my rights and limitations under the NICA Plan have been answered to my satisfaction;
5. I hereby consent to obstetrical services having been given notice pursuant to Florida Statute 766.316 by my physician of the applicability of the NICA upon such obstetrical services.

_____ _____

Patient Name Date

_____ _____

Patient Signature Witness

603 N. Flamingo Road, Suite 360 • Pembroke Pines, FL 33028
1040 Weston Road, Suite 105 • Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027

ADVANCED OBGYN INSTITUTE

CONSENT FOR CARRIER SCREENING FOR GENETIC CONDITIONS

Carrier screening is a type of genetic testing that can tell you whether you carry a gene for certain genetic disorders. It allows you to find out your chances of having a child with a genetic disorder. Most carrier screening testing is for recessive disorders meaning it takes two genes for a person to get a recessive disorder, one inherited from the mother and one inherited from the father. If a person has only one gene for a disorder, he or she is known as a carrier. Carriers often do not know that they have a gene for a disorder.

The American College of Obstetrics and Gynecologists (ACOG) recommends carrier screening for all women for a number of diseases including: Cystic Fibrosis (CF), Spinal Muscular Atrophy (SMA), Fragile X, and hemoglobinopathies such as sickle cell. If both patient and partner are carriers for any of the recessive diseases, we will arrange a consultation with a Perinatologist for genetic counseling and additional testing if needed.

Cystic Fibrosis

Cystic Fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. 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. As a result of scientific advantages these days many with the disease are living into their 20's and 30's.

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 US. SMA destroys nerve cells that affect voluntary movement. The most common form affects infants in the first month of life and can cause death between 2-4 years of age. SMA does not affect the learning process and there is no cure or treatment.

Fragile X

The most common inherited cause of mental retardation is Fragile X syndrome. 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.

Hemoglobinopathies

A hemoglobinopathy is any inherited disorder that affects the number or shape of red blood cells in the body. More than 270 million people worldwide are carriers of genetic disorders of hemoglobin. Examples include sickle cell disease and the different forms of thalassemias.

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CONSENT FOR CARRIER SCREENING FOR GENETIC CONDITIONS

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 disorders.
- 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.
- The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.
- **We are not aware if your insurance covers this test, therefore you may get a bill from the lab. Please check the CPT codes for each test with your insurance: Cystic Fibrosis (81220), Fragile X Syndrome (81243), Spinal Muscular Atrophy (81401)**

☐ **I want** Carrier Testing ☐ **I do not want** Carrier Testing

_____ _____

Patient Name Date

_____ _____

Patient Signature Witness

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CONSENT FORM FOR FETAL CHROMOSOMAL SCREEN:
FIRST AND SECOND TRIMESTER SCREEING

Babies may be affected with chromosome abnormalities, the most common being Down Syndrome, a disorder that leads to intellectual disabilities and other birth defects. Generally, risk of chromosome abnormalities becomes greater as the age of the expectant mother increases. For mothers 35 years of age or more at the time of delivery, the standard recommendation is to offer a genetic amniocentesis: the diagnostic option. Other screening options are however also available.

Since any pregnant woman can be at risk for chromosome abnormalities, therefore, all pregnant women are offered prenatal assessment for chromosome abnormalities by screening or diagnostic testing regardless of maternal age or other risk factors.

Each option has relative advantages and disadvantages. Your options are as follows:

First Trimester Screening

This screening test includes a sonogram to measure the amount of fluid accumulation at the back of the baby's neck (nuchal translucency) and one blood sample. First screen helps to identify babies at increased risk of Down syndrome or Trisomy 18, but does **not** identify risk for open neural tube defect (spina bifida). Another blood sample should be taken in the second trimester to analyze the risk of open neural tube defect. First Screen detection rates for Down syndrome and Trisomy 18 are lower than Integrated Screen, but the results are available earlier in the pregnancy. It is performed between 10-13 weeks

Integrated Screening

This screening test combines the measurement of the nuchal translucency as described above with two blood samples between 11-13 weeks and 15-20 weeks. The result of this screen will not be available until after the second blood sample has been analyzed. This screen has a high detection rate for Down syndrome, Trisomy 18, and open neural tube defect; however there is a false positive rate of 1 %. False negative results have also been reported.

Quad Screen

This is a single blood test obtained at approximately 16-20 weeks. Detection rate for Down syndrome and Trisomy 18 are lower than with the Integrated Screen; but detection rate for open neural tube defect are the same.

Cell free DNA (NIPT)

The newest screening test available is NIPT or cell free DNA. It isolates and analyses DNA from the placenta that is circulating in the mother's blood. It is the most reliable blood test for detecting Down syndrome, Trisomy 18 and Trisomy 13, with a false positive rate of approximately 0.5%. False negative results have also been reported. At the present time, insurance companies may only reimburse for this testing for patients who have an increased risk based on age, family history or ultrasound findings.

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CONSENT FORM FOR FETAL CHROMOSOMAL SCREEN:
FIRST AND SECOND TRIMESTER SCREEING

No screening
You may choose not to undergo any screening test. Patients who feel that they would not intervene if the baby should have a problem may prefer this option.

Follow up for increased risk testing
It is important to understand that all screening tests are limited; a result that is within the normal range does not necessarily mean that there are no chromosomal abnormalities present. It means that the risk of chromosome abnormalities is low. Also a result that shows increased risk does not mean that the baby actually has a chromosomal abnormality. Mothers whose test results show an increased risk will be offered further evaluation with a perinatologist which will include diagnostic testing such as amniocentesis which can determine whether the baby has a chromosomal abnormality or not.

Consent
I understand that there are benefits and limitations for any test, including false positives and false negative results. All my questions have been satisfactorily answered. I understand that testing is voluntary and I may decline testing at any point**. I understand that my insurance company may not cover these services and I agree to provide payment.**

I choose:
___First Trimester Screening
___Integrated Screening
___Quad Screen
___Cell-free DNA
____None

_____ _____
Patient Name Date

_____ _____
Patient Signature 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 means that you can infect others with the virus and that you must take precautions to prevent spreading the infection. If your test is positive, you will gain 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 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

_____ _____

Patient Name Witness

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

_____ _____

Patient Name Witness

Upper Respiratory Illness:
NO Advil
NO Nyquil
Tylenol, 1-2 tablets every 4-6 hours
Saline Nasal Sprays for Congestion – Ocean Air
Sudafed or Actifed, 1 tablet every 4-6 hours as needed
Robitussin DM or Triaminic, 2 teaspoons every 4-6 hours for cough
Gargle with warm salt water
Lozenges for cough or sore throat
Vicks or other Menthol ointments
Vaporizers, hot Showers, or humidification for congestion
Warm, moist compresses on the face for sinus pain
Plenty of Fluids / Warm Tea

Morning Sickness
Acupressure Point Wristbands
Vitamin B6, 25-50 mg twice a day
Ginger Ale
Chamomile or Peppermint Tea
Papaya Chewable Tablets
Dry Crackers
Emetrol or Emecheck (over the counter)

Heartburn
Maalox
Tums
Mylanta
Pepcid AC

Diarrhea
Lomotill
Kaopectate
Immodium

Constipation:
8-10 glasses of water a day
Fruits and Vegetables
Bran diet
Warm Fluids
Prune Juice
Metamucil, one rounded teaspoon in 8 oz. of liquid for 2-3 days

Allergies
Zyrtec
Benadryl

Insomnia (difficulty sleeping)
Melatonin
Unisom
Benadryl

Hemorrhoids:
Tucks
Metamucil
Bran
Pericolace Stool Softener
Annusol

Heartburn
Maalox
Tums
Mylanta
Pepcid AC

Diarrhea
Lomotil
Kaopectate
Immodium

ADVANCED OBGYN INSTITUTE

CONSENT FOR USE OF PICTURE

Patients often give our providers at Advanced OBGYN Institute a family picture or a picture of the newborn. For us to place it in our picture wall, consent is required. This consent is to certify that you allow us to proceed as described above.

Consent

I, (Name)_____, (age if minor) _____ hereby freely and voluntarily consent to the use and publication of my pictures by Advanced OBYGYN Institute for any and all purposes from this date forward until I revoke this consent in writing notwithstanding any prohibition as may be contained in Section 540.08, Florida Statues.

Advanced OBGYN institute has the right, among other things to use photograph as needed. I understand I will not receive any compensation for the appearance of the above-named person.

I have read this consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing the consent.

Patient Name: _____

Patient Signature: _____ Date_____

Name of Parent/ Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian: _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am **revoking** this consent. I understand that every effort will be made to remove this item from the display within a reasonable time frame.

Signature: _____ Date: _____

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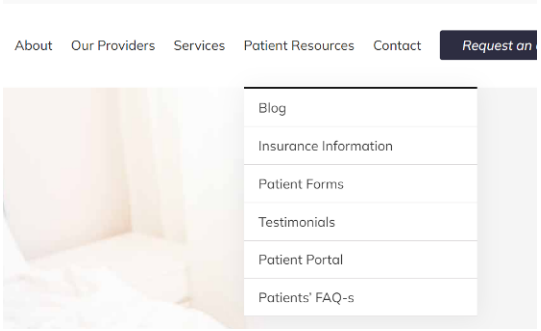
ADVANCED OBGYN INSTITUTE

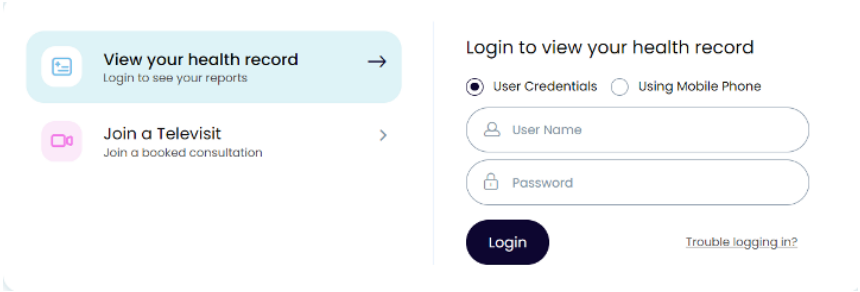
PATIENT PORTAL INFORMATION

Patient can now access their laboratory results through the portal. Please let the staff know your email address to help you activate your account. The portal can be accessed either via the website or via the Healow app. The patient portal is a secure, convenient, and easy way to access your health information.

Via the website

- Go to: https://www.toplinemd.com/advanced-obgyn-institute/
- Then click on Patient Resources, then Patient Portal





Via the Healow app

- Set up the Healow smartphone app in four easy steps
  - Download the Healow app from App Store (iPhone) or Google Play (Android Phone)
  - Search our practice "Advanced OBGYN Institute" by entering the practice code:
  - Enter your portal username and password login
  - Set up your PIN to securely access your health records

Practice Code
BECBCA

603 N. Flamingo Road, Suite 360 • Pembroke Pines, FL 33028
1040 Weston Road, Suite 105• Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027