Authorization for Release of Health Information to Brooklyn Birthing Center

Patient Name:	Date of Birth:
Patient Address:	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to CONFIDENTIAL HIV / AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV / AIDS-related information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV / AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Provider (or Entity) to Release this Information:

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

6. Name and Address of Provider (or Entity) to Receive this Information:

Brooklyn Birthing Center
2183 Ocean Avenue Tel: 718-376-6655
Brooklyn, New York 11229 Fax: 718-336-4113

7. Purpose for Release of Information:

☐ Continuing medical treatment at the facility specified in Item 6

☐ Personal reasons ☐ Other: _____

☐ Litigation / attorney review ☐ Insurance: Insurance Company Name: _____ Claim File #: _____

8. I authorize the release of:

☐ Current pre-natal records including history and physical, all original lab work, and ultrasound reports.

☐ Pap and GC/CT cultures done within 6 months of current pregnancy.

☐ HIV / AIDS-related Information.

9. If not the patient, name of person signing form:	**10. Authority to sign on behalf of patient:**

All items on this form have been completed, my questions about this form have been answered, and I have been provided a copy of the form. This authorization will expire 6 months from the date hereof, unless another expiration date is specified here: _____.

Signature of Patient or Representative Authorized by Law: _____ Date: _____

Witness Statement / Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and / or the patient's authorized representative.

Staff Person's Name / Title: _____ Signature: _____ Date: _____

* Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that disclosure will not reasonably be expected to be detrimental to the patient or another person.

PATIENT INFORMATION:

NAME:	DATE OF BIRTH:	SSN:
ADDRESS:	CITY:	ZIP:
PRIMARY PHONE:	OTHER PHONE:	
E-MAIL:	EMPLOYER / OCCUPATION:	
MARITAL STATUS: ____MARRIED ____SINGLE____WIDOWED ____DIVORCED	DO YOU LIVE WITH YOUR PARTNER? _____YES _____NO	
ETHNICITY (optional, check all that apply): ____Hispanic or Latina ____Black or African American ____Asian ____White, Non-Hispanic ____Native American ____Other: _____ ____Multiracial: _____	IF HISPANIC / LATINA (optional, check all that apply): ____Puerto Rican ____Cuban, Dominican, or other Caribbean ____Mexican or Chicana ____Central American: _____ ____South American: _____	
PREFERRED DELIVERY SITE: ____Brooklyn Birthing Center (BBC) ____Maimonides Medical Center (MMC) (hospital)* ____Unsure *We deliver clients planning a VBAC or pregnant with multiples at MMC	IF INTERESTED IN A HOSPITAL DELIVERY: ____I feel more comfortable with a hospital birth ____My partner or family member(s) prefer a hospital birth ____I want an epidural ____VBAC, twins, or medical reason (explain): _____ ____Other (explain):_____	
PHARMACY NAME / LOCATION:	DATE OF LAST PERIOD: ESTIMATED DUE DATE:	

PARTNER'S INFORMATION (IF APPLICABLE):

NAME:		DATE OF BIRTH:	SSN:
ADDRESS (IF DIFFERENT THAN ABOVE):		CITY:	ZIP:
PRIMARY PHONE:	OTHER PHONE:	EMPLOYER / OCCUPATION:	

EMERGENCY CONTACT:

NAME:	RELATIONSHIP:	PHONE NUMBER:

INSURANCE:

DO YOU HAVE INSURANCE? YES___NO__	IF YES, WRITE INSURANCE NAME / PLAN HERE AND PROVIDE ID:
IS YOUR PLAN A MEDICAID PLAN? YES___NO__	DO YOU INTEND TO APPLY FOR PRENATAL MEDICAID? YES____NO____

COMMUNICATION:

PRIMARY LANGUAGE(S):	CAN YOU READ ENGLISH? YES____NO_____	NEED AN INTERPRETER? YES____NO____

LABORATORY TESTING: WE PROVIDE OUR PATIENTS WITH A MEDICAL ASSISTANT TO DRAW YOUR BLOOD. YOUR CURRENT INSURANCE INFORMATION, IF ANY, WILL BE SENT TO THE DESIGNATED LAB BY YOUR INSURANCE COMPANY. YOU WILL RECEIVE A SEPARATE BILL FOR THE LABORATORY SERVICES FOR WHICH YOU OR YOUR INSURANCE WILL BE RESPONSIBLE. **PREGNANCY:** YOU HAVE A CHOICE TO SEE ANY OR ALL MIDWIVES DURING YOUR PREGNANCY. ONLY THE MIDWIVES SCHEDULED TO BE ON CALL FOR THE BROOKLYN BIRTHING CENTER AND THE HOSPITAL WILL ATTEND YOUR DELIVERY. **PAYMENT:** WE DO NOT ACCEPT ASSIGNMENT OF INSURANCE UNLESS WE PARTICIPATE AS A PROVIDER IN YOUR INSURANCE COMPANY. THEREFORE, IF YOU DO NOT HAVE INSURANCE OR WE ARE NOT IN YOUR INSURANCE COMPANY'S NETWORK, PAYMENT IS DUE AT THE TIME OF YOUR VISIT AND A RECEIPT WILL BE PROVIDED FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT. IF WE ACCEPT YOUR INSURANCE, YOUR INSRUANCE INFORMATION MUST BE PRESENTED AT THE TIME OF VISIT OR YOU WILL BE HELD LIABLE FOR UNTIMELY FILING. PLEASE PAY YOUR CO-PAYMENT AT THE TIME OF YOUR VISIT. THERE WILL BE A $25 CHARGE FOR ANY RETURNED CHECK. **YOU WILL BE RESPONSIBLE FOR THE BALANCE IF YOUR INSURANCE DENIES A PAYMENT.**

My signature below indicates that I agree to release any information requested for insurance purposes and to assign any and all insurance benefits to the above providers. I also agree that in the event my insurance allows balance billing, denies payment for non-eligibility, or does not cover a procedure or test, I will be responsible for any remaining balance.

PATIENT SIGNATURE _____ DATE: _____

Applying for Prenatal Medicaid

IF YOU ARE PREGNANT AND YOUR **GROSS** (BEFORE TAXES AND OTHER DEDUCTIONS) HOUSEHOLD INCOME FALLS WITHIN THE GUIDELINES BELOW, YOU ARE ELIGIBLE FOR NEW YORK STATE PCAP INSURANCE *EVEN IF YOU HAVE ANOTHER NYS SUBSIDIZED PLAN (SUCH AS HEALTHY NEW YORK)*. PCAP WILL REPLACE YOUR SUBSIDIZED PLAN.

Household Income										
		Household Size								
% FPL	Period	Two	Three	Four	Five	Six	Seven	Eight	Each Additional Person	Period
154%	Annual	24,225	30,477	36,729	42,982	49,234	55,487	61,739	6,253	Annual
	Monthly	2,019	2,540	3,061	3,582	4,103	4,624	5,145	522	Monthly
223%	Annual	35,078	44,132	53,186	62,240	71,294	80,347	89,401	9,054	Annual
	Monthly	2,924	3,678	4,433	5,187	5,942	6,696	7,451	755	Monthly

NOTE: Chart effective January 1, 2014; subject to annual income updates

- Pregnant women and infants under age one are eligible at 223%
- A pregnant woman counts as two
- Children 1 through 18 years of age are eligible at 154%

I AM ELIGIBLE FOR PCAP INSURANCE. I WOULD LIKE TO APPLY. YES_____NO_____

If you are interested in receiving care at BBC and you need to apply for Prenatal Medicaid, **please let us know so we can help you complete the application at our office.**

To apply for Prenatal Medicaid at BBC:

Arrange to speak with Marissa Harvey, our Practice Administrator, as soon as possible before your first appointment. She can be reached at 718-336-4119 Ext 105 or mharvey@brooklynbirthingcenter.com. When you schedule your first appointment, ask if Marissa will be available to complete your application.

Bring the following documents:

- Proof of your identity (such as a driver's license or other state-issued photo ID)
- Proof of residency in the state of New York (such as a lease or utility bill)
- Proof of your income for the last 30 days – 90 days, if you want your coverage to be retroactive up to 3 months (paystubs, documentation of other income from the last 30 to 90 days).
- If you are *legally married*, be prepared to include your spouse's proof of income, identity and if you do not share the same last name, your marriage certificate.
- If you have children, please bring their birth certificates and social security cards (if unavailable, please discuss with Marissa)

Patient Privacy Notification Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice Section

This form declares Brooklyn Birthing Center, Inc. (BBC) Privacy Notice policies. BBC, as a Covered Health Care Entity under the Health Information Portability and Protection Act of 1996 (HIPPA), is obligated to protect the privacy of your health information to the best of its ability. Under the provisions of HIPAA, we are authorized to use your Patient Health Information (PHI) for routine treatment, payment, and health care operations without your explicit consent. This type of disclosure must be part of approved routine business transactions relating to payment, treatment, or health care operations, excepting psychotherapy notes, which may not be released. These transactions will normally be with other hospital or insurer business associates, who may have already obtained patient consents in these instances, or already have a direct or indirect treatment relationship with the individual.

Other instances when disclosure does **NOT** require your explicit consent:

- The disclosure is made under an HHS-approved exception, such as to parents of a minor or an individual authorized to act on behalf of another individual.
- You yourself make an official disclosure request.
- The requester is an approved government entity or health oversight agency.
- The law requires the disclosure.
- The disclosure relates to public health activities.
- The entity has reason to believe the individual may be a victim of abuse or neglect.
- The disclosure relates to judicial or administrative proceedings.
- The disclosure relates to law enforcement purposes.
- The disclosure relates to workers' compensation.
- The situation is an emergency. Consent must be obtained as soon as is reasonably possible.
- Consent has been attempted and has been determined impossible to obtain, but may be reasonably inferred or expected given the circumstances.
- **Joint Consent**: If BBC has already entered into a Consent Agreement with the patient as part of a Joint Consent authorized for another health care entity, we will be considered as authorized regarding the provisions of that Disclosure Consent Notice.

Any other use or disclosure of your health information requires your direct written consent. Should BBC require your consent, you will be notified and asked to sign a Patient Disclosure Authorization. You may refuse to sign this authorization. BBC will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on the individual's providing authorization for the requested use or disclosure. Subsequent to signing the Patient Disclosure Authorization, you may revoke such authorization by notifying us in writing at any time. Should you do so, any action taken by us prior to revocation that relied upon the patient's consent shall still be considered valid, to the extent that it was relied upon. Your authorization may also contain an expiration date or other comment limiting the authorization.

You, the patient may also request stricter restrictions regarding the routine business transactions (payment, treatment, and health care operations) described above. BBC is **NOT** required by law to agree to these restrictions, but will consider each request individually.

BBC also reserves the right to change the terms of this privacy notice at any time. You may obtain a copy of this Notice at any time, by mail, e-mail or other electronic means. This Notice is effective April 14, 2012.

Patient Access Request Section

Your medical record is the physical property of our medical concern. You do, however, have rights with respect to your health information. You have the right to:

- Review this Notice of Privacy Practices.
- Authorize uses and disclosures of health information for purposes other than treatment, payment and health operations.
- **Opt-out of disclosure of information to family members or others who may be assisting with your care.**
- Request restrictions on certain uses and disclosures of your health information (however our office is not required to agree to such restrictions).
- Inspect and copy your own health information within reasonable times and availability, and upon proper written notice signed by you, which could incur a charge as allowed by state law.
- Under certain circumstances, to appeal denials of access to your own health information.
- Amend incorrect or incomplete health information, subject to certain limitations.
- Obtain an accounting of disclosures of your health information disclosed after April 14, 2003, subject to certain limitations including a request in writing by you.
- Request communication of your health information by alternative means or at alternative locations. For instance, you may ask that messages not be left on voice mail or correspondence not be sent to your address.
- Revoke your authorization to use or disclose your health information.
- File a complaint with this office or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.

Service Delivery Sites to which this notice applies:
Brooklyn Birthing Center, Inc. 2183 Ocean Avenue, Brooklyn, NY 11229
Maimonides Medical Center, 4802 10th Avenue, Brooklyn, NY 11219

Our Pledge

Your privacy is important to us. BBC will do its utmost to protect your Patient Health Information both internally and externally, and adhere to federal privacy guidelines.

For comments, questions, privacy concerns, or complaints, please contact our Privacy Officer, A. Frances Schwartz, 2183 Ocean Avenue, Brooklyn, NY 12219. Tel 718 376-6655; Fax 718 336-4113; e-mail franschwartz@brooklynbirthingcenter.com.

PATIENT DISCLOSURE AUTHORIZATION FORM

DATE: _____ **PATIENT LABEL:** _____

I acknowledge Brooklyn Birthing Clinic (BBC) has provided me with the *BBC HIPAA Privacy Notification Form*, which details my rights under the Health Information Portability and Accountability Act of 1996 (HIPAA).

I hereby give authorization to disclose my Protected Health Information (PHI) only in the specific manner and to the specific individual(s) directed below.

Recipient of Information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Manner(s) of communication allowed regarding my PHI:

☐ Telephone
☐ Fax
☐ Mail
☐ Email

Restrictions to Disclosure:

☐ Access all medical records
☐ Last visit only
☐ Test results only
☐ Other

I understand this authorization provides that:

- I have the right to access any protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing or email at the address listed below.
- Information used of disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by HIPAA rules.
- BBC will not condition treatment on my providing authorization of the requested use.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____
Patient

GENERAL INFORMED CONSENT AND AGREEMENT

INFORMATION

Childbirth is one of life's peak experiences, and should be viewed as a healthy process. It is a family experience that is shared emotionally, physically and spiritually as the whole family joins together in welcoming its newest member.

It is the responsibility of the Brooklyn Birthing Center (BBC or 'birth center') and health care providers to inform childbearing families of their options in birth settings and the risks and benefits of choosing any of those settings. The setting chosen must be one considered safe and satisfying in meeting the needs expressed by the family.

We offer birthing in a freestanding childbearing center. All care is provided by a team consisting of midwives, their physician consultants, medical director, midwifery director and trained birth assistants. When you register for care you can expect that your prenatal care, birth and postpartum care will be provided only by staff midwives. Should problems arise which require medical care, your care may be managed collaboratively by the midwives and the physician consultant, or an obstetrician you have chosen may take over your care.

It is the policy of BBC that the family may choose an out-of hospital birth if:

1. The expectant mother has an uncomplicated medical and obstetrical history;
2. The expectant mother has a present pregnancy that is proceeding normally;
3. Both partners are in complete agreement about the site of birth; and
4. The expectant mother and her family have chosen to assume the added responsibilities that go along with an out-of-hospital birth.

It is important that the expectant mother and her family understand that all childbirth carries some risk to mother and baby, regardless of site of birth. Certain hazards that exist when birth occurs in a hospital do not exist in alternative settings. Likewise, certain hazards that exist when birth occurs in alternative settings do not exist in the hospital.

Studies of different birth settings have indicated that the outcomes for low-risk women are comparable when birth occurs in or out of the hospital. The staff at Brooklyn Birthing Center has taken every reasonable precaution to insure safety, comfort, and satisfaction for both mother and baby. However, in any particular case, complications may arise suddenly and unpredictably. The following are medical problems which could occur in any birth, regardless of the site of birth:

Major Complications

1. Fetal distress— lack of oxygen for the baby while he or she is still in the uterus
2. Neonatal asphyxia— lack of oxygen for the baby after birth
3. Maternal hemorrhage— excess blood loss during labor or after
4. Preeclampsia or toxemia (pregnancy-induced high blood
5. Amniotic fluid embolism— a drop of amniotic fluid enters
6. Uterine rupture— uterus splits open
7. Cardiac arrest— heart stops beating

Complications Involving the Placenta

1. Placenta previa— placenta partially or completely covers the opening of the uterus
2. Placenta abruptio— placenta separates from wall of uterus before baby is born
3. Retained placenta— all or part of placenta remains inside uterus for an extended time after birth

Complications Involving the Pelvis

1. Cephalopelvic disproportion— baby is too large to fit through mother's pelvis
2. Shoulder dystocia— baby's shoulders become lodged in mother's pelvis after baby's head is born

Complications Involving the Baby

1. Rupture of membranes without labor— amniotic fluid sac breaks prior to onset of labor and labor does not spontaneously begin
2. Cord prolapse or other cord problems— umbilical cord is compressed cutting off oxygen to baby
3. Multiple gestation— presence of more than one baby (twins, triplets, etc.)
4. Malpresentation— baby is in some position other than the normal head-first position
5. Stillborn— baby dies in mother's uterus before birth
6. Meconium— stained amniotic fluid - baby has bowel movement inside uterus
7. Congenital anomalies— birth defects
8. Immaturity or post-maturity— baby is born too early or too late
9. Hyperbilirubinemia— janudice (yellow skin) in newborn caused by too much bilirubin in baby's body after birth

CONSENT AND AGREEMENT

1. Physical Examination

I authorize the midwives, and birth assistants to perform, according to the expertise of each discipline, examinations upon my person to confirm general health and pregnancy status, obtain the usual specimens and perform the usual diagnostic procedures, including, but not limited to: (1) drawing blood, (2) pregnancy tests, (3) urinalysis, (4) determination of blood pressure, (5) internal examination, with and without instruments, (6) obtaining rectal, vaginal, and cervical specimens, including Pap smear. I understand that, even when the above are properly and correctly done, there is potential for infection, tissue damage and other unpredictable medical conditions. I agree that the nurse-midwives, medical consultants and nurses shall be responsible for the performance of their own professional acts only, and the test results shall be the responsibility of those who perform them.

2. Authority to Treat

I authorize the midwives, their physician consultants and nurses to treat, administer and provide as necessary or available to me and my baby: (1) health care, including prenatal education; (2) physical examinations as necessary, (3) diagnostic test and procedures by the obtaining of blood or other specimens; (4) oral, intramuscular, subcutaneous and intravenous medications and local anesthesia; (5) intravenous infusions; (6) delivery of my baby; (7) episiotomy and repair; (8) postpartum care, including home visits; (9) newborn care initially after birth; (10) other procedures related to childbirth as may be deemed necessary. The administration of this care may be in the office, birth center, and elsewhere, including ambulance and

hospital. I grant to the midwives and birth assistants full authority to administer and perform all drugs, treatments, diagnostic procedures, examinations and ministrations to or upon me and my baby.

In case of emergency, I authorize these professionals to take appropriate measures. When specialized equipment or hospitalization is required, I authorize these professionals to transfer me and / or my baby to the hospital from home or birth center.

All of the above is to be performed as deemed necessary or advisable by the midwives, their medical consultants and birth assistants, in the exercise of their professional judgments.

3. Early Transfer

I understand that the BBC staff will, during my prenatal period, attempt to recognize signs which may indicate that the course of pregnancy might significantly deviate from normal, even though such deviation may not necessarily affect the outcome of pregnancy adversely. If such is the judgment of the midwives, the management of my pregnancy shall be transferred to the physician of my choice or my care will be managed collaboratively by the midwives and their physician consultants.

4. Complications of Pregnancy and Birth

I have read and understand the list of complications of pregnancy and birth and discussed them with the midwives. I am aware that the birth center staff has taken every reasonable precaution to insure my safety, comfort and satisfaction. I do understand that these complications may arise suddenly or unpredictably. I am aware that the practices of midwifery, medicine and nursing are not exact sciences. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatment, examinations and procedures to be performed.

5. Preparation

I agree to prepare ourselves for pregnancy and childbirth through attendance at childbirth classes. This includes preparation to perform emergency childbirth should labor proceed rapidly. I will prepare myself, to the extent possible, to go through birth without narcotic analgesics, sedatives, tranquilizers or anesthesia.

6. History and Right to Withdraw

I understand that the safety of care by the midwives and their consulting physicians and of out-of-hospital birth depends upon my medical history and the information which I provide about me. I affirm that such information is, and will be, accurate and complete to the best of my knowledge. In addition, I agree to follow all the rules, regulations and policies of the birth center. I also understand that I may voluntarily choose not to remain at the Brooklyn Birthing Center and transfer care to the hospital for myself and / or my baby.

7. **Research**

In an effort to support the development of birth center and midwifery care, I consent to the sharing of information from my medical record for statistical reporting and publication, as long as my confidentiality is insured. I also understand that the Brooklyn Birthing Center m ay, from time to time, be used for the purpose of teaching student nurse-midwives.

8. Transfer to the Hospital

I agree to transfer from the birth center to the Maimonides Medical Center in the event of a circumstance in which the midwife feels that hospital care is required or advised. Should hospitalization become necessary, my records may be made available to the doctor and / or hospital staff. In the event of an emergency, I understand that I will be transferred to the hospital and the physician considered appropriate by the midwife, according to standard procedures. Depending upon the nature of the complication, and the hospital to which I am transferred, my care at the hospital will be managed either by the midwife, the midwife in collaboration with the obstetrician, or exclusively by the obstetrician. All hospital and physician expenses incurred at that time, or any other time, shall be my obligation and are not included in the birth center fees.

9. Postpartum Responsibilities

I understand that the birth center staff will provide all normal postpartum care, including a home visit within 24-72 hours after birth. The nurse or midwife will perform an initial newborn physical assessment. It is my obligation to arrange for pediatric care to begin immediately upon discharge of the infant from care at BBC. I understand that, if my baby is born at the birth center, my pediatrician / family physician/nurse practitioner must be seen of the infant birth within 72 hours.I will provide the name of my chosen pediatrician to the birth center staff by 35 weeks gestation. If my baby is born in the hospital, a pediatrician / family physician will manage the baby's care in the hospital.

I understand that childbirth and the early postpartum period are stressful times for families, both physically and emotionally. I agree to provide for necessary assistance during the birth and the first week postpartum. This includes obtaining a support person for any older sibling who will be present for the labor and / or birth. I understand that if I am unable to make these arrangements, I will not be eligible for an out-of-hospital birth.

10. Miscellaneous

Brooklyn Birthing Center presently has capacity to birth three births simultaneously. Should the BBC reach capacity when I require admission, I understand that my care provider will make arrangements for me to be cared for at Maimonides Medical Center by BBC staff midwife or physician consultant.

Affirmation

I have toured the Brooklyn Birthing Center and have attended a required orientation session conducted by the BBC staff.I have read the *General Informed Consent and Agreement* packet and the Orientation Packet, including the *Statement of Client's Rights and Responsibilities* and the section titled, *Financial Obligation of the BBC Client*. I know that I may request another copy of these documents for my records if I so choose.

I have read all of the above thoroughly and carefully, as well as reviewed it with a staff midwife provider, and allowed to ask any questions which have been fully satisfied. I hereby give consent for treatment and care for myself and my baby.

_____ _____

Signature of Patient* Witness (support person, if any)

_____

Signature of Partner (if present) Date Signed _____

_____

Signature of Staff Midwife Date Signed _____

Orientation Date _____ **Patient Label**

***Important Note**

When a patient is unable to sign, a legally authorized person should sign on the patient's behalf and complete the following with their own information. If more than one person is signing, each person should fill out the information below (attach additional pages, if necessary):

Patient's Representative (print name):* _____ Date: _____

Patient's Representative (sign here):_____

Relationship to patient: _____

If person signing is not nearest relative, print name, address and/or telephone number of nearest relative.

INFORMED CONSENT FOR WATER BIRTH

Brooklyn Birthing Center offers women the choice of water immersion as a method for coping with the stress and pain of labor and birth. It is safe for both mother and infant so long as appropriate guidelines are followed.

ELIGIBILITY
Water immersion for labor and birth will be limited to mothers who request it, who have been screened and approved prenatally and who have signed this informed consent form.

BENEFITS
Water immersion during labor and/or birth can enhance relaxation, reduce perceptions of pain and promote supportive care. Studies suggest that entering the water in the first stage of labor can:

- Promote comfort
- Enhance mobility
- Facilitate relaxation
- Alleviate stress (decrease catecholamines and increase oxytocin and endorphins)
- Reduce pressure on the abdomen, better blood circulation and more oxygen to the mother and baby due to the buoyancy of the water.
- Reduce lacerations, as water relaxes the pelvic floor muscles.
- Reduce rate of cesarean section.
- Increase a woman's confidence in her own ability to manage her labor, which in turn promotes feelings of control over the process.

Laboring women who use water immersion are more likely to achieve a natural spontaneous birth and be satisfied with their birth experience.

Criteria for using the Waterbirth Tub

1. Singleton pregnancy
2. 37-42 weeks gestation
3. Cephalic presentation
4. Absence of pregnancy complications
5. Absence of bleeding greater than bloody show
6. Normal fetal heart tones
7. Clear amniotic fluid – women may labor on the tub if meconium is present and FHTs are reactive

Contraindications

1. Known untreated communicable blood or skin infection
2. Suspected infection
3. Excessive vaginal bleeding
4. Positive hepatitis B antigen or hepatitis C antibody
5. Meconium stained amniotic fluid may labor, but not deliver in tub

During a Waterbirth

The water temperature is kept between 95 and 100 degrees F. Staying in the water for too long (more than two hours at a time) or getting in the tub too early may slow labor down. Therefore, it is recommended that you not get into the tub until you have reached about five centimeters in cervical dilation.

Women must leave the water for assessment in the circumstances of the fetal heart rate pattern is abnormal. Women may be asked to leave the tub for the birth of the placenta, suturing, evaluate blood loss, or if the midwife determines there is a concern for the well-being of the mother or baby.

Risks

Evidence suggests that the clinical outcomes for babies born into water are not significantly different to those not born in water.

The risk of the baby breathing water into its lungs, while extremely low, is more likely to occur when the baby is not well. A woman whose baby is assessed to be compromised must leave the water for further assessment.

Observations may be completely normal and a baby may be born in an hypoxic state. Such babies are those most at risk of gasping and inhaling water during a water birth.

I hereby affirm that I understand the benefits and risks explained in this informed consent form and will adhere to instructions of my midwife care giver at Brooklyn Birthing Center in regard to my eligibility to immerse in a water tub during labor and delivery, as well as to instructions to leave the water tub if, and when directed.

Signature of Mother _____

Date: _____

PATIENT LABEL_____

2183 Ocean Avenue, Brooklyn, New York 1229 Tel 718-376-6655
www.brooklynbirthingcente r.com

CONSENT TO PARTICIPATION IN STUDENT TRAINING

In an effort to ensure that new providers are trained in the midwifery model of care, Brooklyn Birthing Center (BBC) seeks your cooperation in preparing the nursing and midwifery students who intern with us.Their roles range from observation to full participation in all aspects of client care. Students are closely supervised by certified midwives at all times.

No student may be involved in you care without your express permission. We ask that you let us know whether you give such permission and to what extent. If you wish to refuse any student involvement, you should feel free to do so. Should you, at any time, change you mind about student participation, please let us know.

We hope that you will consider helping us educate the care providers of the future in our unique setting.

_____ I agree to full participation in my care.

_____ I agree to limited student participation in my care. Please specify:

_____ I refuse student participation in my care.

Date: _____

Signature of Mother _____

Signature of Midwife _____

2183 Ocean Avenue, Brooklyn, New York 1229 Tel 718-376-6655
www.brooklynbirthingcente r.com

LEAD SCREENING EVALUATION FORM

Name: **ID:**

You may be exposed to high levels of lead without knowing it. Please answer the following questions.

1. Do you live in a house that was built before 1960 with recent or ongoing renovations, including painting, sanding or remodeling?

   _____ Yes _____ No _____Don't know

2. Do you or others in your household have a job that may involve lead exposure? (Examples: automotive repair workers, motor vehicle worker, industrial machinists, oil field workers, storage battery or battery recycling workers, glass makers, pottery makers, plumbers, brass / copper casters, valve and pipe fitters, battery worker, inorganic pigment users, smelting, foundry, and refining workers, firing range workers, elevated highway constructors, building renovation or demolition, bridge / tunnel construction.)

   _____Yes _____No _____Don't know

3. Do you have any traditional folk remedies or cosmetics that are not bought in a regular drugstore? or homemade, such as Alkohl, Azarcon Bali-goli, Ghazard, Greta, Suma, and Paylooah?

   _____Yes _____No _____Don't know

4. Have you had the urge to eat things, which are not food, such as clay, dirt, plaster, paint chips or ice?

   _____Yes _____No _____Don't know

5. Do you or others in your household have a hobby or activity likely to cause lead exposure? (Examples: making stained glass, copper enameling, bronze casting, pottery, jewelry making, casting ammunition/fish weights, collecting and other fine arts, liquor distillation, hunting and target shooting?)

   _____Yes _____No _____Don't know

6. Do you use leaded crystal glassware or pottery that was handmade or homemade?

   _____Yes _____No _____Don't know

7. Does your house, school, workplace, or other site you frequent contain lead pipes, solder, or have lead in the water?

   _____Yes _____No _____Don't know

Interviewer's signature _____Date_____

Serum Level indicated: _____Yes _____ No _____ Refer to M.D.

2183 Ocean Avenue, Brooklyn, New York 1229 Tel 718-376-6655
www.brooklynbirthingcente r.com

Medication History Authority

I hereby give my permission for Birthing Medical Group and Brooklyn Birthing Center to obtain my medication history from current and past pharmacies using a national electronic database. This will help to ensure that my medication history is up to date in my electronic medical record.

Name DOB

Signature Date

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Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.

- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the conidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____ Date: _____

Signature: _____

Important Note

When a patient is unable to sign, a legally authorized person should sign on the patient's behalf and complete the following with their own information. If more than one person is signing, each person should fill out the information below (attach additional pages, if necessary):

Patient's Representative's Name: _____ Date: _____

Patient's Representative's Signature: _____

Relationship to patient: _____

If person signing is not nearest relative, print name, address and/or telephone number of nearest relative.