Patient Information:

Name:	Date Of Birth:	SSN:
Address:	City:	Zip:
Primary Phone:	Other Phone:	Email:

Marital Status: Married___ Single___ Widowed___ Divorced___	Do you live with your partner? Yes___ No___
Ethnicity (optional, check all that apply): ___ White ___ Asian ___Native American or Alaskan Native ___Black or African American ___Mixed Race	Do you identify as Hispanic or Latino/a? Yes___ No___ ___ Puerto Rican ___ Cuban ___ Dominican ___ Mexican, Mexican American, or Chicano/a ___ Central or South American: _____ ___ Other: _____

Date of Last Menstrual Period: Estimated Due Date:	Height: Pre-pregnancy weight:	Highest level of education completed: Occupation:

Gender Identity (optional, check all that apply):	Gender Pronoun (optional, check all that apply):
____ Identifies as Male ____ Identifies as Female ____ Transgender Male/Female-to-Male (FTM) ____ Transgender Female/Male-to-Female (MTF) ____ Gender non-conforming (neither exclusively male nor female) ____ Additional gender category / other, please specify ____ Choose not to disclose	___ She/Her/Hers ___ He/Him/His ___ They/Them/Theirs ___ Ze/Zir/Zirs ___ Ze/Hir/Hirs ___ No pronoun use

Spouse or Partner's Information (If Applicable):

Name:	Phone Number:

Other Emergency Contact:

Name:	Relationship:	Phone Number:

Insurance:

Do You Have Insurance? Yes___ No___ Is your plan a Medicaid or CHIP Plan? Yes___ No___	Insurance Name:	Provider ID#:
Policy Holder Name:	Date Of Birth:	Relationship:
Address (if different from above):	City:	Zip:

Income and Eligibility:

Are you enrolled in prenatal Medicaid or WIC? Yes___ No___ Are you eligible to enroll in Medicaid or WIC based on your income? Yes___ No___ Unsure___	If you are eligible for prenatal Medicaid or WIC, *or* if your income is low, you may be eligible for other services, such as a visiting nurse or a labor / postpartum doula. Are you interested in hearing about programs and services for low-income pregnant clients? Yes___ No___

Communication:

Primary Language:	Can You Read English? Yes__ No __	Need An Interpreter? Yes__ No__

Laboratory Testing: Your current insurance information, if any, will be sent to the designated laboratory. 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 for reimbursement. If we accept your insurance, your insurance 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 balance.

Client Signature _____ Date_____

Out of Network Consent Letter

Brooklyn Birthing Center is a participating provider in many health insurance plan networks. We ask that you verify whether we accept your insurance plan by requesting a Verification of Benefits through Digital Billing, our billing service.

For a Verification of Benefits report, please e-mail Molly at digitalbillingcorp@gmail.com. Please note that Digital Billing charges $25.00 for this service. Digital Billing will help you to understand any anticipated out-of-pocket costs, such as co-pays and deductibles, and will help you to obtain any special authorizations that may be required by your insurance plan.

It is also important for you to know that any laboratory services you receive at the Brooklyn Birthing Center, are not included in the birthing center's charges. Laboratories bill for their services separately and may or may not participate in the same health plans as the birthing center. You may contact the lab directly at any time for a list of their fees and accepted insurances.

We anticipate that you will need the services of other facilities, such as sonographers or other allied providers. It is **your responsibility** to contact the facility regarding their fees and accepted insurances. For your convenience, the names of some of the facilities that we frequently use are listed below.

Brooklyn Birthing Center has a fee of $50.00 to use Nitrous Oxide at the time of delivery.

List of Physicians or Facilities:

New Beginnings: 8405 Fort Hamilton Parkway Brooklyn, NY 11209 **Phone:** 718-745-6500
MMC Perinatal Center: 5014 Fort Hamilton Parkway Brooklyn, NY 11219 **Phone:** 718-283-7979
Sunrise Lab: 800-782-0282
Quest Lab: 800-223-0570

Client name: _____ Date: _____
Signature of Acknowledgement: _____

BROOKLYN MIDWIFERY GROUP/ BROOKLYN BIRTHING CENTER

Insurance Letter

I, _____, acknowledge that my VOB (verification of benefits) was completed for the health insurance that will be my ONLY insurance throughout my prenatal care, delivery and postpartum.

In the event that my insurance will change, it is my responsibility to inform the office staff of the insurance change and to have a new VOB done, at a separate fee of $25.

In the event I have another primary insurance (coordination of benefits), other than the VOB originally done, I will be held responsible to backdate the other insurance termination date, from the date of my first prenatal visit through my postpartum visit. If terminating the other insurance policy will be not be possible, I will be held responsible for $4000 for professional fees and $5000 for facility fees (amount will vary depending upon weeks gestation at which I was seen for my initial prenatal visit) to Brooklyn Birthing Center.

I, _____, acknowledge that the **insurance information for my newborn** will be updated with the SAME insurance plan that I am currently active with.

If I have a Medicaid Managed Care plan it is my responsibility to have the same Managed Care Organization's insurance for my unborn effective his/her date of birth.

If I have commercial insurance it is my responsibility to add my unborn to my insurance policy immediately after I give birth and effective his/her date of birth.

I am also responsible to provide Brooklyn Birthing Center with my newborn's insurance identification numbers so that payment can be processed.

In the event this cannot be accomplished effective his/her date of birth I will be responsible to pay a fee of $2500 to Brooklyn Birthing Center.

X_____ Date _____

Credit Card Holder Name _____

Credit Card Holder's Full Address _____

Credit Card Number_____

Expiration date _____ Security CVV number _____

Signature_____*-

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 these 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 the 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
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, however 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 pressure)
5. Amniotic fluid embolism—a drop of amniotic fluid enters the mother's bloodstream causing clots
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 abruption—placenta separates from wall of uterus before baby is born
3. Retained placenta—all or part if 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 mothers 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—jaundice (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 by 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 with repair, and/or repair of laceration; 8) postpartum care, including home visits; 9) newborn care initially after birth, including Vitamin K injection and the application of Erythromycin ointment to infant's eyes; 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 in hospital. I grant to the midwives full authority or administer and perform all drugs, treatments, diagnostic procedures, examinations and ministrations to or upon me and my baby, with the assist of the birth assistants.

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. Referrals

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 Rights to Withdraw

I understand that the safety of care by the midwives and their consulting physicians and 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 if 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 a hospital; for myself and / or my baby. If done so at 26 weeks gestation or beyond, the BBC reservation agreement will apply.

7. Research and Student Participation

I understand that Brooklyn Birthing Center participates in the American Association of Birth Centers' Perinatal Data Registry. Participation involves allowing information from my medical record regarding my pregnancy to be entered into a secure online data registry. The care that I receive during pregnancy, labor, birth and postpartum, and the care that my newborn receives, will not be altered in any way as a result of participation in this data registry. My health record from my pregnancy may also be reviewed by one of the project administrators during a site visit in order to confirm that the data entered in the data registry is accurate.

I understand that information about me and my pregnancy will be kept confidential and secure, and only the people working with Brooklyn Birthing Center or AABC's Perinatal Data Registry will see my data. Only people working with Brooklyn Birthing Center will be able to connect the data collected with me specifically. As required by the federal Privacy Rule (HIPAA), no identifying information will be seen by those conducting the project except my infant's date of birth and my 5-digit zip code.

I understand that my data will be kept on file, and may be used later by other researchers who are studying specific parts of birth center or midwifery care. My information will be completely de-identified prior to being used by any researcher, and all information, including my infant's date of birth and zip code, will be removed.

In an effort to support the development of birth center and midwifery care, I consent to the sharing of information from my medical records for statistical reporting and publication, as long as my confidentiality is insured.

I also understand that the Brooklyn Birthing Center may, from time to time, be used for the purpose of teaching students. I have the option of permitting, limiting or refusing student participation in my care (see Consent to Participate in Student Training).

8. Transfer to Hospital

I agree to transfer from the birth center to a hospital-based practice (usually 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 the 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 a midwife, an affiliated midwife, an

affiliated midwife in collaboration with the obstetrician, or exclusively by an affiliated 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 of 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 of BBC. I understand that, if my baby is born at the birth center, my pediatrician/family physician/nurse practitioner must see the infant birth within 72 hours. I will provide the name and phone number of my chosen pediatrician to the birth center staff by 35 weeks gestation. If my baby is born in a 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. Wheelchair Accessibility

I understand that the Brooklyn Birthing Center's wheelchair lift may be out of service. I understand that the birthing center floor is six steps above the sidewalk level, and the midwifery group's office is six steps below the sidewalk level. Brooklyn Birthing Center and Brooklyn Midwifery Group staff members are willing to assist guests with limited mobility when safety and staffing allow. I will contact the staff to discuss any concerns about building accessibility.

11. Miscellaneous

Brooklyn Birthing Center presently has capacity to care for three laboring, delivering, or postpartum clients simultaneously. In the extremely unlikely event that BBC is at capacity when I require admission, I understand that my care provider will make arrangements for me to be cared for Maimonides Medical Center by an affiliated midwife or an affiliated physician consultant.

12. Specimen/Tissue Disposal

I hereby consent to disposal of my placenta by Brooklyn Birthing Center according to standard medical waste procedures unless I decide to take my placenta or the midwife determines the need to send it for pathology evaluation.

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.

Client Name (Print): _____

Signature: _____ Date: _____

Client Privacy Notification Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT 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 (HIPAA), 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 Client 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 Client 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 and official disclosure request.
- The requester is an approved government entity of 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 Client 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 of disclosure of your health information requires your direct written consent. Should BBC require your consent, you will be notified and asked to sign a Client 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 Client

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 Client's consent shall still be considered valid, to the extent that it was relied upon. Your authorization may also contain an expiration date or event limiting the duration of the authorization.

You, the Client may also request stricter restrictions regarding the routine business transactions (payments, 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.

Client Access Request Section

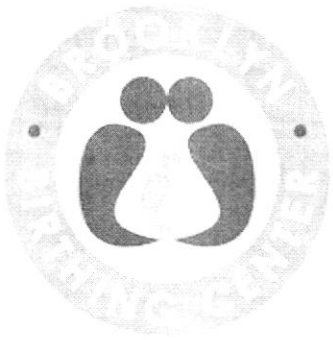
Your medical Record is the physical property of our medical concern. You do, however, have rights with respect to your health information. Your have the right to:

- 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 heath 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
Brooklyn Midwifery Group, 1074 Dekalb Avenue, Brooklyn, NY 11221

Our Pledge

Your privacy is important to us. BBC will do its utmost to protect your Client Health Information both internally and externally, and adhere to federal privacy guidelines. For comments, questions, privacy concerns, or complaints, please contact our Director of Midwifery, Trinisha Williams, 2183 Ocean Avenue, Brooklyn, NY 11229. Tel 718-336-4119; E-mail: twilliams@brooklynbirthingcenter.com.



Client Disclosure Authorization Form

I acknowledge Brooklyn Birthing Center (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 Client: _____

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

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 office in writing or email.
- 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.

Client Signature: _____ Date: _____

MEDICATION HISTORY AUTHORITY

I hereby give my permission for Birthing Medical Group and Brooklyn Birthing Center to obtain my medication history from the last 13 months using our national pharmacy registry. I understand that this information will be automatically uploaded into my electronic medical records (chart).

_____

Name

_____

Signature

_____

Date

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 becoming infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality 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.

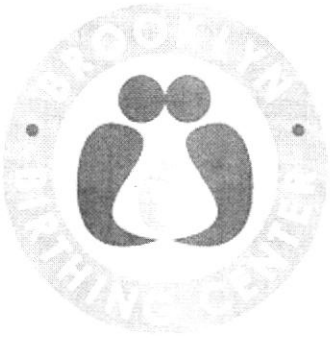
I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I 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 sex or needle-sharing partners of possible exposure.

I may revoke my consent verbally 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 record.

Client's Name: _____ Date: _____
Client's Signature: _____

Important Note
When a Client is unable to sign, a legally authorized person should sign on the Client'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):
Client's Representative's Name: _____ Date: _____
Client's Representative's Signature: _____
Relationship to Client: _____

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



Lactation Information and Consent

Brooklyn Birthing Center provides breastfeeding classes and individual breastfeeding counseling to all of our expecting clients and their families. Breastfeeding is a skill that takes knowledge and practice to be successful. All clients are required to attend one of our prenatal breastfeeding classes or an individual consultation with one of our lactation consultants. These sessions provide women and their families an opportunity to learn about how their breasts produce milk, how to breastfeed their babies, and how to make sure their babies are getting the breastmilk they need to grow and thrive. In our group classes, clients have a chance to learn from each other's questions and to have conversations about their fears and aspirations about breastfeeding their baby.

The individual or one-on-one breastfeeding counseling sessions allow Clients to ask specific questions about her anatomy and physiology and to get feedback on the struggles she may personally face. It is also a time to discuss the support systems in the Clients' life and who is going to care for the breastfeeding client and baby.

Before scheduling an appointment for either our breastfeeding class or a one-on-one breastfeeding session, please call your insurance to make sure this service is covered. Brooklyn Birthing Center can provide you with a list of insurances that may cover the class or session if you ask, however this is not a guarantee that your insurance will pay. Please note that our breastfeeding classes and breastfeeding one on one sessions are at a fee of $55 each visit for mom, and a one-time fee of $55 for baby. This will be the Clients' responsibility to pay in the event your insurance does not cover the service.

Client Signature: _____ Date: _____

CONSENT TO PARTICIPATION IN STUDENT TRAINING

In an effort to ensure the 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 role 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 your 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 your 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.

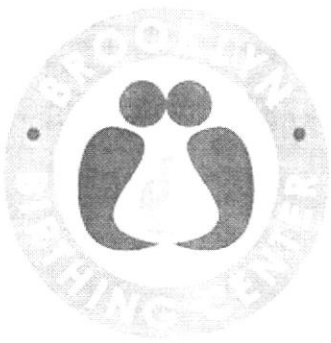
_____ I agree to full participation.
_____ I agree to limited student participation in my care. Please specify:

_____ I refuse student participation in my care.

Date: _____

Signature of Client: _____

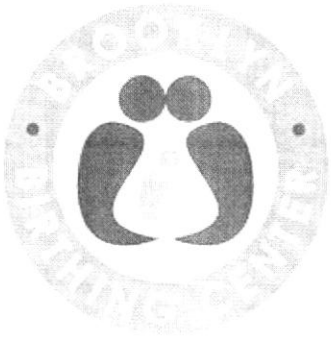
Signature of Midwife: _____



Client Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	o	o	o	o
2. Feeling down, depressed, or hopeless	o	o	o	o
3. Trouble falling or staying asleep, or sleeping too much	o	o	o	o
4. Feeling tired or having little energy	o	o	o	o
5. Poor appetite or overeating	o	o	o	o
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	o	o	o	o
7. Trouble concentrating on things, such as reading the newspaper or watching television	o	o	o	o
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless than you have been moving around a lot more than usual	o	o	o	o
9. Thoughts that you would be better off dead, or of hurting yourself	o	o	o	o

Name: _____ Date: _____



Nutrition Assessment Form

Name: _____ Age: _____ Pre-pregnancy weight: _____

Current weight: _____ Weeks gestation: _____

Please circle any digestive problems you have:

Lack of appetite Nausea Vomiting Diarrhea Constipation

Chewing / Swallowing Difficulty Heartburn / Indigestion Reflux

How do you deal with this problem? _____

Do you currently take any medications/vitamins/supplements/herbals? _____

Do you smoke/drink alcohol/use drugs? If yes, indicate amount _____

Do you now or have you ever suffered with eating disorders / weight / nutrition problems? If yes, describe:

_____

Do you have enough money to buy food for yourself?

Who shops for food? _____ Who cooks your food? _____

Typical method of preparing your food: bake broil boil steaming frying

Do you have facilities available to cook your food? _____

How many times per week do you eat out? _____ Types of food you eat when out? _____

Do you keep a special diet (vegetarian / vegan / gluten free, etc.)? _____

How would you describe your daily activity level: _____

Do you exercise regularly? (type, how many X per week for how long) _____

Do you drink water regularly? _____ # of glasses of water per day _____

Circle meals you eat regularly: Breakfast Lunch Dinner

Do you skip meals regularly? _____ How often? _____

In a typical day how often do you snack? _____ Examples of snacks: _____

Do you typically (circle): eat dinner with family eat in front of TV eat in bed eat on the run

24-hour Diet Recall

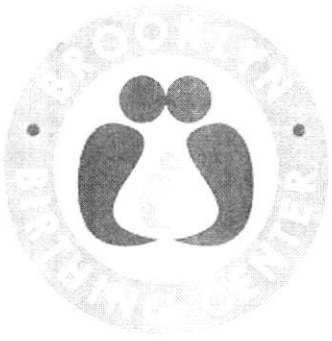
Please list the type of food and the amount eaten in the past 24 hours.

Breakfast:

Lunch:

Dinner:

Snacks:



LEAD SCREENING EVALUATION FORM

Name:

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 machinist, 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 are 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 other than 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 making, 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 _____

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

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: 718-336-4119
Brooklyn, New York 11229 — Fax: 718-943-0739

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.