

AUG/24/2013/TUE 07:21 PM

FAX No. 801 266 7243

P. 004

American Healthcare Services, P.C.

CHART NUMBER: 1562

PATIENT INFORMATION FORM

TODAY'S DATE: 8-9-10 LMP: \_\_\_\_\_ DATE OF BIRTH: [REDACTED] AGE: 18  
NAME: D [REDACTED] B [REDACTED]  
ADDRESS: [REDACTED]  
CITY/STATE/ZIP: [REDACTED] COUNTY: Salem  
TELEPHONE (HOME): 856 [REDACTED] WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_  
ALTERNATIVE PHONE NUMBER: 609 - [REDACTED]  
CITY & STATE OR COUNTRY OF BIRTH: Salem NJ RACE: \_\_\_\_\_  
HISPANIC (circle one) YES or NO NO If so, specify origin (Puerto Rican, Dominican, etc.) \_\_\_\_\_  
HIGHEST GRADE COMPLETED (K-12) 12 OR GED (circle one) YES or NO  
COLLEGE EDUCATION-HIGHEST LEVEL COMPLETED: \_\_\_\_\_  
CAN WE CONTACT YOU AT THE ABOVE NUMBERS? (Circle one) YES or NO  
SOCIAL SECURITY NUMBER [REDACTED]  
MARITAL STATUS single  
HOW ARE YOU PAYING FOR YOUR VISIT TODAY? (Circle one) SELF PAY  
\*\*\*Insurance must be verified before appointment.

INSURANCE

MEDICAID

MEDICAL HISTORY INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

A history of fainting?.....YES or NO  
A reaction or allergy to Novocain or other local anesthetics?.....YES or NO  
A reaction or allergy to shellfish or iodine?.....YES or NO  
When did you last eat or drink anything? Date: 8-9-10 Time: 9:00 a.m.

GYNECOLOGICAL AND PREGNANCY HISTORY

First day of your last normal menstrual period.....04 / 1 /

Have you had any bleeding since your last period? (Circle one) YES or ☒ NOHave you been experiencing any pregnancy symptoms (such as breast tenderness, nausea, frequent urination, fatigue, etc.)? (Circle one) ☒ YES or NOIf yes, for how long? two weeksHave you ever been told that your uterus is different or unusual? YES or ☒ NOIncluding THIS pregnancy, how many times have you been pregnant? (#) noneHow many live births have you had? (#) 0 How many are living? (#) 0

Date of first live birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of last live birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you ever had a miscarriage or stillbirth? YES or ☒ NO If yes, how many and how far along were you into the pregnancy when it occurred? How many weeks or months? \_\_\_\_\_Have you ever had an abortion before today? YES or ☒ NO If yes, how many prior abortions? \_\_\_\_\_Have you ever had problems with pregnancy (problems such as tubal or ectopic pregnancy, toxemia, Caesarian (C-Section), etc.)? YES or ☒ NO

If you have had a C-Section, why did you have it? \_\_\_\_\_

Have you had heavy bleeding (hemorrhage) with delivery, abortion, or miscarriage? YES or ☒ NOWhat are your concerns about having this abortion?  
\_\_\_\_\_  
\_\_\_\_\_FAMILY HISTORY

Have your parents, brothers, or sisters had:

High cholesterol..... ☒ YES ☐ NODeath of heart attack before age 50..... YES ☒ NODiabetes ..... YES ☒ NOBreast cancer..... YES ☒ NODid your mother take DES or other hormones while pregnant with you? YES ☒ NODid your mother have miscarriages or problems with pregnancies? YES ☒ NO

Please circle the number for any of the following you have experienced:

- |   |   |
|---|---|
| 1. Asthma                                       | 24. Blood transfusion                       |
| 2. Allergies                                    | 25. Anemia                                  |
| 3. Breathing/lung problems                      | 26. Sickle cell disease                     |
| 4. Epilepsy (seizures, fits)                    | 27. Operations/surgery                      |
| 5. Fainting, dizzy spells                       | 28. Breast problems                         |
| 6. Severe headache                              | 29. Emotional problems                      |
| 7. EEG (brain wave test)                        | 30. Drug/alcohol problems                   |
| 8. Eye vision problem                           | 31. Gonorrhea                               |
| 9. High or low blood pressure                   | 32. Chlamydia                               |
| 10. Heart trouble                               | 33. Syphilis                                |
| 11. Chest pains                                 | 34. Herpes                                  |
| 12. Rheumatic fever                             | 35. Infection of tube/uterus/ovary          |
| 13. Hepatitis (liver infection/jaundice)        | 36. Genital warts                           |
| 14. Liver disease/mono                          | 37. Vaginal infections or unusual discharge |
| 15. Stroke                                      | 38. Abnormal pap smear                      |
| 16. High cholesterol                            | 39. Ovarian cyst                            |
| 17. Diabetes                                    | 40. Cryosurgery/Cone Bx                     |
| 18. Gall bladder disease                        | 41. LEEP/Laser                              |
| 19. Kidney/bladder problems                     | 42. Cancer                                  |
| 20. Stomach/intestinal                          | 43. Bleeding/pain with intercourse          |
| 21. Thyroid problems                            | 44. HIV Positive or AIDS                    |
| 22. Blood clots (or taken blood thinning drugs) |   |
| 23. Bleed easily or have Hemophilia             |   |

Other: \_\_\_\_\_

Do you know your blood type? (A) (B) (AB) (O) ..... (+) or (-)

Have you arranged to receive birth control from the clinic or physician who referred you to us? YES or NO/

Would you like us to provide birth control at your post-operative exam with us? YES or NO

Do you smoke cigarettes? YES NO If yes, how many? \_\_\_\_\_

Please note what type of birth control you have used in the past. How long did you use this method and did you experience any problems?

Trinesta

October 2009

## AMERICAN WOMEN'S SERVICES

SOCIAL HISTORYCHART NUMBER 1567DATE: 8-9-10 AGE: 18NAME: B [REDACTED] D [REDACTED] [REDACTED]  
(LAST) (FIRST) (MI)BIRTHDATE: [REDACTED]

Note: All information that would permit identification of an individual will be held in strict confidence and will not be disclosed without written permission. By law, we are required to report suspected child abuse, release information regarding positive response for sexually transmitted diseases, and comply with subpoenas for medical records.

ADDRESS: [REDACTED]  
(STREET, CITY & STATE)[REDACTED]  
(COUNTY & ZIP CODE)EMERGENCY CONTACTNAME: C [REDACTED] B [REDACTED] RELATIONSHIP: mom PHONE: 856 [REDACTED]CLINIC OR MD WHO REFERRED YOU HERE: NAME \_\_\_\_\_  
CITY: \_\_\_\_\_In case we need to reach you we should call: Home ☒ Work \_\_\_\_\_ Other \_\_\_\_\_  
(We will not use the American Women's Services name when calling.)May we contact you by mail (plain envelope)? YES or NO  
If YES, there is no need to read further. If NO, contact me at the following:

ALTERNATIVE ADDRESS or PHONE #: \_\_\_\_\_

Signature: [REDACTED] C/O \_\_\_\_\_ Date: 8-9-10

Patient Number: \_\_\_\_\_

American Healthcare Services, P.C.

Informed Consent for Abortion after 14 Weeks

I, DB, hereby request that I receive a abortion (sometimes known as a "medical abortion") from Dr. DB, (hereafter referred to as "My Doctor") an independently contracted physician working with American Healthcare Services, P.C.

Initials of PatientDB

I understand that I am 21 weeks (LMP) pregnant as measured by ultrasound. I also understand that I am in my second trimester and that the risks of abortion are greater in the second trimester than in the first trimester because I am further into my pregnancy.

DB

I understand that one alternative to me is to continue my pregnancy and give birth to a baby. I also understand that if I were to continue my pregnancy that I would have several options available to me including adoption, foster care, or raising the child myself. I further understand that American Healthcare Services, P.C. can provide me with referrals for pre-natal care as well a list of licensed adoption agencies, if I decide to continue my pregnancy.

DB

I understand that the benefits of abortion to me are that I will terminate my pregnancy now, avoid continuance of my pregnant state, and avoid a full-term delivery.

DB

I understand that there are several RISKS associated with an abortion at this stage of pregnancy. I understand that these risks include, but are not limited to, the following:

DB

ALLERGIC OR UNUSUAL REACTIONS TO MEDICATIONS  
BLEEDING AND/OR HEMORRHAGE AND/OR BLOOD TRANSFUSION  
UTERINE RUPTURE  
HOSPITALIZATION AND/OR SURGERY  
LOSS OF FUTURE FERTILITY AND/OR STERILITY  
INFECTION  
AMNIOTIC FLUID EMBOLISM  
DEATH

DB

These complications have been explained to me and I understand what they mean. No guarantee has been made to me as to the results of the abortion. I understand that the risk of complication from my abortion is approximately 1 to 2 in 100.

DB

I also understand that continuing my pregnancy and undergoing a full-term delivery, is generally considered to be at least as dangerous, and probably more dangerous, than a abortion.

DB

I understand that a late abortion is different than an early surgical abortion in that I will be given medications which will soften, dilate and efface my cervix, and which will induce uterine cramping, uterine contractions, and possibly a mini-labor state. I further understand that, with my doctor's assistance, it is possible that I may will deliver a fetus.

DB

I give my consent to my Doctor and to American Healthcare Services, P.C. to administer to me medications to cause an abortion. I understand that these medications include, but are not limited to, Mifepristone, Misoprostol, Oxytocin, Gemeprost, Methylergonovine, Digoxin, Vasopressin, Lidocaine, Ergotrate, Monsel's Solution, Silver Nitrate, Hydromorphone, Codeine, Demerol, Doxycycline, Fentanyl, Midazolam and other medications of my Doctor's choosing. I understand and consent to the administration of

these drugs orally, intramuscularly, vaginally, or intravenously. I further understand that although all of these medications are F.D.A. approved drugs, not one of them is F.D.A. approved for the purpose of late-term abortion. Nevertheless, I consent to my Doctor's legally accepted decision to utilize these medications in an "off-label" manner in the dosages and with the timing that my Doctor feels is best. I further understand that my Doctor is practicing evidence-based medicine, drawing from multiple techniques which are described in peer-reviewed medical literature, to provide me with what my Doctor believes is the safest method for abortion. I further understand that this abortion method may not be covered by my health insurance.

DB

I understand that although my Doctor may possibly prescribe and/or administer pain medications, narcotics, sedatives and/or other medications designed to eliminate pain, nevertheless, a delivery is an inherently uncomfortable experience. Everyone is unique and no two people experience the event in precisely the same manner. I acknowledge that I may experience cramps, contractions and/or a mini-labor state, as well as a delivery, and this is likely to be perceived by me, at times, to be unpleasant or uncomfortable. Additionally, I understand that some of the medications that may be given to me have been shown to cause side effects in less than 10% of patients (such as nausea, fever, and/or diarrhea). I understand that such side effects, if they occur, are temporary, limited, and usually resolve spontaneously in a short time. However, if I should develop any such side effects, I hereby consent to my Doctor giving me additional medications to counteract these side effects. Nevertheless, I understand that, although every safe effort will be made to alleviate any unpleasantness, no guarantee has been made that my Doctor will always be able to keep me comfortable.

DB

I understand that with the latest advances in neo-natal intensive care, modern neonatologists are daily pushing back the earliest dates at which fetuses have been reported as being able to survive. I understand that historically, before the advent of hospitals and modern medicine, fetuses below 32 weeks almost all died, and therefore some people date "natural viability" as between 32 to 34 weeks. Nevertheless, I also understand that today it is routine for fetuses to survive at 28 weeks LMP and that it is not uncommon for fetuses as early as 24 weeks to survive (after a stay in the NICU). Further, I understand that, although uncommon, there are reports in the medical literature of fetuses surviving at 22 weeks or even 21 weeks, although if they survive, many of these children suffer from physical or mental disabilities, or both.

DB

I understand that my Doctor may induce intrauterine fetal demise by injecting my fetus with a drug, Digoxin, designed to slow the fetus's heart rate and gently cause the death of the fetus. I understand that my Doctor may accomplish this by inserting an amniocentesis needle, under ultrasound guidance. I understand that there are risks to this technique, including inadvertently inserting the needle into other organs, hemorrhage, and other risks to me. Nevertheless, I consent to this method of inducing fetal demise, if my Doctor should decide to utilize it.

DB

I understand and agree that my Doctors may dilate my cervix with manual dilators and insert laminaria, which are a type of osmotic dilator, into my cervix for the purpose of slowly dilating my cervix.

DB

I understand and consent that after my delivery, or possibly before or during it, my Doctor may utilize a suction canula to aspirate blood, amniotic fluid or placenta, if necessary. Additionally, I understand and consent that my doctor may utilize a sharp curette to remove any adherent placental parts.

DB

I further understand and consent that my doctor may utilize a variety of obstetrical maneuvers to turn or adjust the fetus for delivery, or to massage my uterus after the delivery to expel the placenta or to stop bleeding.

DB

Although I have requested my Doctors to conduct an abortion, and my Doctor's intention are to prefer non-surgical methods, nevertheless, surgical techniques may be necessary, and I consent to the use of surgical abortion techniques.

DB

I understand that because I am undergoing an abortion and because of the nature of the medications, the timing of my delivery cannot be finely controlled by my Doctor. I understand that there is a chance that I may need to deliver late at night or early in the morning. I agree that I will show up for all of my appointments on time and that I will call my Doctor or American Healthcare Services, P.C. immediately if I have any problems. I understand that if, after starting the abortion with laminaria or drugs, I were to leave the office and fail to return to my Doctor, that my failure to return could possibly be fatal to me.

DB

I further understand that abortions are controversial and late-term abortions are even more controversial. I understand that some hospitals or hospital staff may be opposed to late abortions. As a result, I understand that if I have a problem, these hospitals and/or their staff may therefore be very reluctant to become medically involved in assisting me in my late abortion process. I also understand that under the pending federal Abortion Non-Discrimination Act, the staff at the hospital or emergency room may legally refuse to care for me because I am a woman who has chosen to have a late abortion.

DB

I have been provided with an accurate toll-free telephone number ((1-800-226-7846) that I may call 24 hours per day to reach my Doctor.

DB

I understand that following my abortion I cannot drive an automobile for six (6) hours, and I agree to have someone come to the office to assist me in returning home.

DB

I understand that my Doctor is an independently contracted physician by American Healthcare Services, P.C., and not an employee of American Healthcare Services, P.C.. Therefore, I hereby release AHS from all liability to me for the actions of my doctor.

DB

In the event of an unexpected complication during the abortion procedure, I request and authorize my Doctor to do whatever is necessary to protect my health and welfare. If I am a minor, I realize that complications requiring additional medical treatment may result in my parents or guardians being informed of my medical care.

DB

I understand that the financial responsibility for any emergency medical care not provided at AHS is my own. Even if my Doctor or AHS refers me to a hospital because of a complication from my abortion, it will be my responsibility to arrange for payment of necessary fees, and not the responsibility of AHS or my Doctor.

DB

I understand that once I have swallowed the medication dispensed to me or had my laminaria inserted, that I have begun my abortion and that it most likely cannot be stopped. Further, if I were to attempt to stop my abortion once it was already started, then I understand that the child that I may deliver after a half-completed abortion may very well suffer from permanent mental or physical birth defects, or death.

DB

I understand that the abortion process may take two or even three days, and that it is my responsibility to return to my Doctors and to AHS the next day in order to complete the abortion process. I promise to return to AHS and to my Doctor as often as I am asked by them to return. I understand that neither AHS nor my Doctor can force me to return, and that it is my responsibility to voluntarily return to complete the abortion.

DB

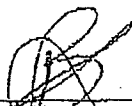
I declare that I have carefully thought about my options, considered the risks, benefits and alternatives available to me, and that I am certain that I wish to terminate my

pregnancy. I further declare that after making this decision and beginning my abortion, I will not attempt to reconsider my decision or attempt to stop the abortion in the middle of the process. I also promise and declare that once I have started the abortion process, I will return to AHS and to my Doctor and complete the abortion process. Further, if I should change my mind and stop the abortion mid-process, or fail to return to my Doctor to complete the abortion, then on behalf of myself and my future child, I hereby release and hold harmless my Doctor and AHS from any and all liability of claims (to either me or my future child) resulting from damages that I may suffer or that my future child may suffer (including the damages resulting from the permanent physical or mental disability of my child), as a result of the partial abortion that was provided to me at my request.

DB

I also declare that all of my questions have been fully answered by my Doctor and by the AHS staff, that I have had ample opportunity to consider my choices, and that I am making my decision to terminate my pregnancy at this late stage of my own free will and without coercion or unwelcome pressure from any other party.

Finally, after carefully reading all of the information on this four-page Informed Consent Agreement, and after initialing every paragraph on the Agreement, and after weighing my options, and after discussing my situation with a counselor, and after considering the nature of the abortion method as well as the risks, benefits and alternatives of a abortion, I declare my intention to have a abortion and I hereby consent to, and request that, my Doctor and AHS provide me with a abortion under the provisions of this Consent Agreement.

  
Witness Signature and Date

    8-19-1  
Patient Signature and Date

     
Patient Signature



American Healthcare Services, P.C.

Surgical Counseling Record

Name: O [REDACTED] B [REDACTED]

Date: 8/9/10  
8/12/10

Chart#: 1362

1. Counselors role and purpose of session explained?
2. Alternatives to abortion presented?
3. If choice is abortion, were feelings discussed?
4. Is patient comfortable with decision?
5. Asked if patient is being forced to terminate pregnancy?
6. Social/ Medical history reviewed?
7. Abortion procedure explained?
8. Fact sheet reviewed, explained?
9. Consent form signed and witnessed?
10. Birth Control choices discussed?
11. Need for post-operative exam discussed?
12. Was patient told of risk of abortion?
13. Was risk of carrying pregnancy to term explained?
14. All questions answered?

Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N

If from Pennsylvania, were Department of Health materials offered?  
Did the patient wish to review the materials?

Y	N
Y	N

Comments:

It is sure about her decision

Counselor Signature



Date

8/9/10  
8/12/10

## American Women's Services

## Consent for Laminaria Insertion

Patient Name: D [REDACTED] B [REDACTED] Chart Number: 1562

PLEASE READ CAREFULLY, ASK ANY QUESTIONS, AND BE CERTAIN THAT YOU FULLY UNDERSTAND THIS FORM BEFORE YOU SIGN.

The purpose of inserting laminaria is to gently dilate (open) the cervix so the doctor can remove the pregnancy with less risk of harming the cervix. Laminaria are made from a natural, organic product that absorbs water from the cervix making the laminaria expand to gently open the cervix. Once the laminaria are inserted, they must be removed within 24 hours and either changed, or the pregnancy evacuated from the uterus.

**IF LAMINARIA ARE NOT REMOVED, LIFE-THREATENING COMPLICATIONS CAN ENSUE. THESE INCLUDE SEVERE INFECTION, HIGH FEVER, HEMORRHAGE, SEPTIC SHOCK, AND DEATH.**

It is possible that the membranes may spontaneously rupture (the "water breaks") while laminaria are in the cervix. This may cause labor and delivery of the fetus.

There is a small risk of infection because laminaria are made from a natural, organic product. I understand that I will be given antibiotics to take to prevent the risk of infection.

I understand the reasons for inserting laminaria and the possible risks of having laminaria inserted into my cervix. It has been explained to me that no one can guarantee or promise that I would be able to continue to carry this pregnancy if I change my mind about having the abortion after the laminaria have been inserted. I understand that the insertion of laminaria into my cervix **COMMITTS ME TO THE TERMINATION OF THE PREGNANCY.**

I hereby give my permission to insert laminaria into my cervix. I understand I must return to the office for the abortion. If I do not return for the abortion, I completely absolve American Women's Services, their staff and doctors, from any responsibility for any complications which result from my failure to return and perform the abortion procedure.

Patient's Signature: [REDACTED] Date: 8-12-10Witness: [REDACTED] Date: 8/12/10

**CONSENT FOR USE OF MISOPROSTOL  
IN VOLUNTARY SURGICAL ABORTION**

Your doctor has recommended that you receive the medication Cytotec (misoprostol) before undergoing your voluntary pregnancy termination. Before you consent to taking this medication, you must be informed about the risks and benefits.

The medication misoprostol (Cytotec) is usually prescribed to prevent stomach ulcers in people who take aspirin or Advil-like medications.

The manufacturer, in its instructions to doctors, advises them specifically NOT to prescribe it to pregnant women because of the possibility of miscarriage by softening the cervix (opening to the uterus or womb) and expulsion of the pregnancy by causing contractions.

It is precisely this effect of misoprostol, which is useful in making induced, voluntary abortion safer and easier for the doctor to perform. This is particularly true in women who have never had a vaginal delivery and/or those who are more than twelve weeks pregnant. It is usually given 2 or 3 hours before the procedure.

By accepting this pre-medication you realize that misoprostol is being used in an unconventional way, and not for the reasons which the manufacturer originally intended.

Once you have taken the medication, either orally or vaginally, you must not change your mind about having the abortion. Misoprostol can cause serious birth defects if the abortion is not completed. Also, no guarantee can be made that your personal health would not be affected should you choose to continue the pregnancy.

Other possible, but not all adverse effects of misoprostol include nausea and vomiting, abdominal cramps, headache or allergic reaction.

I, D. B. (print name), have read and understood the materials presented to me in this consent form. I have had all my questions answered and wish to receive misoprostol before my surgical pregnancy termination,

D. B.  
Signature

8-12-10  
Date

[Signature]  
Witness

8/12/10  
Date

American Healthcare Services, P.C.

Chart # \_\_\_\_\_

## AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Patient Name: [REDACTED]Date of Birth: [REDACTED] SS#: [REDACTED] Medical Record #: \_\_\_\_\_Address: [REDACTED] City, State, & Zip: [REDACTED]Day Phone: 8576- [REDACTED] Evening Phone: \_\_\_\_\_

I Authorize American Healthcare Services, P.C. to Release My Health Information to: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, &amp; Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Health Information to be Released:

I specifically authorize release of the following information:

☐ Entire Medical Record

Specific Information Only:

☐ History and Physical Exam☐ Progress Notes☐ Procedure Record☐ STD Testing & Results☐ HIV Related Information☒ Other: Ultra Sound

Dates: \_\_\_\_\_

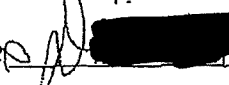

8-12-10

## Purpose of the Release of Information:

☒ At my request, OR☐ Specify reason: \_\_\_\_\_

Conditions of Authorization

1. This Authorization will expire on: \_\_\_\_\_
2. I may revoke this Authorization at any time by notifying American Healthcare Services, P.C. in writing, and the revocation will be effective on the notification date unless the information has already been released.
3. I have been offered a copy of this signed Authorization form.

Signature of Patient:  

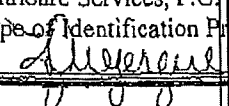
Date: 8-12-10

Signature of Parent/Legal Guardian/Authorized Person (if necessary): \_\_\_\_\_

Date: \_\_\_\_\_

For American Healthcare Services, P.C. Use

Date Request Completed: 8/12/10 Type of Identification Presented: \_\_\_\_\_

Signature of Staff Completing Request: 

American Healthcare Services, P.C.

REDUCED FEE REQUEST FORM

Chart Number 150

I D. [REDACTED] B. [REDACTED] do not have insurance coverage or can not/will not use my insurance or else my insurance plan will not cover abortion services. I therefore, must pay out of pocket for my medical services. However, because I am unable to afford American Healthcare Services P.C.'s standard fee for abortion starting at \$1,115.00, I wish to apply for a hardship reduced fee for the services rendered to me.

Signature: [REDACTED] B. [REDACTED]

Date: 8-9-10

AUG/24/2010/TUE 07:23 PM

FAX No. 801 266 7243

P. 018

American Healthcare Services, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH  
INFORMATION PRIVACY PRACTICES

I acknowledge that I am in receipt of American Healthcare Services, P.C.  
Notice of Health Information Privacy Practices.

Signature: [Redacted] A. B. [Redacted]

Date: 8-9-10

AUG/24/2010/TUE 07:23 PM

FAX No. 801 266 7243

P. 019

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH  
INFORMATION PRIVACY PRACTICES

I acknowledge that I am in receipt of American Women's Services Notice of  
Health Information Privacy Practices.

Signature:                                          

Date: 8-12-10

April 14, 2003



## American Healthcare Services, P.C.

Chart Number 1502

## OBSTETRICAL SONOGRAM REPORT

Patient Name D [REDACTED] B [REDACTED]Date 8/9/10LMP 3Weeks by Date           Fetal# ✓ 1 2 3Position            vertex            breech ✓ trans

## Fetal Measurements

BPD 51 mm 21 weeks 4 daysCRL            mm            weeks            daysFL 35 mm 20 weeks 5 daysGestational Sac            mm            weeks            daysPlacenta            ant            post            fundalFluid            normal            polyhyd            oligohydramniosHeartbeat            normal            slow            fast            absentMovement            normal            slow            fast            absentFINAL ESTIMATED GESTATIONAL AGE: 20 4 2/3 (Weeks) 21 5Comments trans Abcd x/y 2- gest ageUltrasound Technician Signature [Signature]Physician Signature [Signature]

VMD



Laminaria Insertion & Induction of Intrauterine Fetal Demise.Patient's Name: D [REDACTED] B [REDACTED] Date: 8/12/10 Chart#: 1562Vital Signs: BP: 104/70 Pulse: 85 Temp: 97.4

\*\*\*\*\*  
 I have discussed with the patient the abortion she has requested and I believe she is sufficiently mature and intelligent to understand the nature and consequences of her decision.

The patient was placed in the lithotomy position. The perineum was prepped and draped.

On Pelvic Examination:

Vagina ☒ WNL ☐ Other: \_\_\_\_\_  
 Cervix ☒ WNL ☐ Other: \_\_\_\_\_  
 Adnexa ☒ WNL ☐ Other: \_\_\_\_\_  
 Uterus ☒ WNL ☐ Other: \_\_\_\_\_ [ ] Ant [ ] Mid [ ] Post

Approximate Size of Uterus:

13 14 15 16 17 18 19 20 21 22 23 24 25

\*\*\*\*\*  
 [ ] Periumbilical prep was done. 10cc of 1% Lidocaine injected subcutaneously. Under ultrasonographic guidance a 7-inch spinal needle was inserted through the skin and into the fetus.

cc. (500mcg/2cc) Digoxin was injected to cause fetal demise.

\*\*\*\*\*  
Laminaria insertion: Total number of Laminaria Inserted: 7 LOCAL/TWILIGHT

5 10mm Laminaria Japonica ☐ Membranes ruptured.  
 \_\_\_ 8mm Laminaria Japonica ☐ Umbilical chord ligated.  
 \_\_\_ 6mm Laminaria Japonica ☐ Lamicel 5mm. # \_\_\_\_  
 \_\_\_ 5mm Laminaria Japonica ☐ Lamicel 3mm. # \_\_\_\_  
 \_\_\_ 4mm Laminaria Japonica  
 \_\_\_ 3mm Laminaria Japonica  
2 2mm Laminaria Japonica

Sterile gauze packing was then placed in the vagina. Patient was taken to the recovery room for observation.

Medications administered and/or prescribed to her:

\_\_\_ Misoprostol tabs, \_\_\_ x 200 mg, p.o. started at \_\_\_ am/pm, and repeated every \_\_\_ hrs.  
 \_\_\_ Misoprostol tabs (\_\_\_ #) placed p.v.  
 \_\_\_ Mifepristone tabs 100 mg p.o. at \_\_\_\_  
 \_\_\_ Hydrocodone  
 \_\_\_ Dilaudid  
✓ Doxycycline 100 mg B.I.D.  
✓ Other: Tylenol #3

Return to Vonk office on 8/13 at 8 am/pm.MD signature: [Signature]

American Healthcare Services, P.C.

Recovery Room RecordPatient Name: [REDACTED]Chart#: 1562Date: 8/12/10Type of Procedure: 2nd TriGestational Weeks: 21.5

Time	BP	P	Initials	Bleeding			Cramping			Comments
				Min	Mod	Heavy	Min	Mod	Heavy	
11:35	121/88	78								
11:45	127/92	87								
	/									
	/									
	/									
	/									

☐ Ibuprofen/Tylenol administered for abdominal cramping  
(Ibuprofen/Tylenol administrado para el dolor abdominal)

☒ Nourishment given post-abortion (Alimento dado despues del aborto)

☒ Urged patient to stay for one hour (Instó al paciente a permanecer por una hora)

☒ Instructed patient to follow-up with a 2 week visit

(Paciente fue instruido a regresar en 2 semanas para seguimiento)

☒ Verbal and written post-operative instructions, emergency contact and 24 hour hotline number given to patient with her understanding

(Instrucciones verbales y escrita posoperatorias, contacto de emergencia número de línea directa dado al paciente con su comprensión)

☒ Antibiotic given and explained to pt. with pt.'s understanding

(Antibiótico dado y explicado al pt. con la comprensión de pt.)

I have received the above information and medications:

(He recibido de información y medicinas)

[REDACTED]  
Patient Signature  
(La firma del paciente)

Additional Comments: I.V. started in \_\_\_\_\_ area with \_\_\_\_\_ of Ringer's Lactate infusing with \_\_\_\_\_ of Pitocin added. I.V. was removed without any problems. Patient tolerated the procedure well and denies any complaints or discomfort.

[Signature]  
Recovery Room Nurse

8/12/10  
Date

Time

American Healthcare Services, P.C.

### Post-Laminaria Insertion Instructions

You have just completed the first step of your abortion procedure. The material that the doctor has just placed in the opening of your uterus is called laminaria. It is a type of seaweed that is compressed and prepared for medical use. Between now and the time of your procedure it will absorb moisture and swell, opening your cervix in a safe and natural way. This is being done for your comfort and safety.

The laminaria is designed not to go too far up into your uterus, so don't worry about the possibility of this happening. It will in no way interfere with your using the bathroom. You should also not be concerned if the laminaria or gauze packing falls out. If this does occur, just be sure to tell us when you return to the office. The doctor will remove the laminaria before he/she does your procedure.

#### Do Not do Any of The Following Between Now and Your Appointment Time:

- Put anything inside of your vagina
- Have sexual intercourse
- Use tampons
- Take a tub bath

You May Take Showers and you MUST take the antibiotics, which have been prescribed, as directed.

We can be reached at our 24-hour HOTLINE at 1-800-ABORTION. Our answering service can reach us at any time, so please do not hesitate to call if you are having any problems before your next appointment, such as severe labor-like cramps, fever or bleeding. Do not be concerned about spotting or having a yellow discharge from your vagina.

YOU MUST BE ON TIME TOMMOROW. Also, you should have someone with you who can help you return home. It is important for your safety that you do not eat or drink anything for 8 hours prior to your appointment, THIS INCLUDES WATER, GUM AND CANDY. Also, DO NOT, take any medication, drugs or drink any alcohol before your procedure without your doctor's okay.

The day of the procedure, please wear loose fitting clothing (i.e., jogging pants, appropriate underwear, t-shirts). Do not wear many layers of clothing. You want to be as comfortable as possible. There are also gowns available that you have the choice of using.

Remember that your abortion really begins when the laminaria is inserted into your cervix. Therefore, you MUST return for your procedure at the scheduled time. If an emergency arises which will cause you to be late for your appointment, CALL US IMMEDIATELY.

Your next appointment is schedule at 8:00 on 8/12/10

*American Medical Services, PC*AMA SIGN-OUT FORM

I have been informed by the medical staff of American Medical Services, PC that it is in my best interest to remain on the premises of their office for at least one hour after my abortion procedure. I understand that this recommendation is being made to protect me by allowing the medical staff to monitor me for any possible complications that might arise as a result of my abortion procedure. I understand that these complications could include bleeding, hemorrhage, post-abortion syndrome, infection, as well as other complications. I also understand that the potential consequences of these complications, if left untreated, could include surgery, loss of fertility, and/or death. Understanding all of the above, I still wish to leave the office early, even though this is against my medical advice. I will not hold American Medical Services, PC, their doctors, or any of their staff responsible for the consequences of my leaving early.

Patient Name: D [REDACTED] B [REDACTED]Patient Signature: [REDACTED] B [REDACTED]Date: 8-12-12Witness: CK



## Second Trimester Non-Surgical Abortion

Name: D. [REDACTED] B. [REDACTED] Chart # 1562 Date: 8/12/10

Age: \_\_\_\_\_ LMP: \_\_\_\_\_

\*\*\*\*\*  
LABORATORY TEST RESULTS:VITAL SIGNS: BP: 104/70 Pulse: 85 Temp: 97.4 Ht: 5'11/2 Wt: 122BLOOD: Hct/Hgb: 1 RH: +veURINE: Glu/Pro: neg/ neg LSPT: \_\_\_\_\_ Signature of Lab Tech. [Signature]\*\*\*\*\*  
Non-Surgical Abortion - Delivery Notes, Date: \_\_\_\_\_ Time: Start \_\_\_\_\_ End: \_\_\_\_\_Ultrasound examination on \_\_\_\_\_ revealed the gestational age to be \_\_\_\_\_ wks LMP.  
On \_\_\_\_\_ a 2<sup>nd</sup> ultrasound examination [ ] did, [ ] did not confirm fetal demise.

The patient was brought into the exam room and placed in the lithotomy position. The patient was noted to be having contractions. The gauze and laminaria were manually removed.

Vagina	[ ] WNL	[ ] Other: _____		
Cervix	[ ] WNL	[ ] Other: _____	Dilated: _____ cm	Effaced: _____ %
Adnexa	[ ] WNL	[ ] Other: _____		
Uterus	[ ] WNL	[ ] Other: _____	[ ] Ant [ ] Mid [ ] Post	Size: _____ wks.

Pain Management: Paracervical block: 1% lidocaine with vasopressin and oxytocin.  
[ ] Conscious sedation: \_\_\_\_\_ mg Midazolam \_\_\_\_\_ ug Fentanyl. [ ] Other: \_\_\_\_\_

The patient was continuously monitored by pulse oximetry, VS readings, cardiac rhythm and visual observation. The patient remained awake and talking throughout the delivery.

BP: \_\_\_\_\_ / \_\_\_\_ Ps: \_\_\_\_\_ O<sub>2</sub> Sat: \_\_\_\_\_ Cardiac Rhythm: NL/ABN Staff Int: \_\_\_\_\_

The patient [ ] did or [ ] did not, spontaneously deliver the fetus and placenta.

Adjunctive measures used to facilitate delivery of the fetus/placenta and/or to stop bleeding:  
\_\_\_\_ Obstetrical maneuvers  
\_\_\_\_ Forceps assistance to delivery.  
\_\_\_\_ Sharp curettage of the endometrium.  
\_\_\_\_ Vacuum aspiration of amniotic fluid, blood, placenta, or retained POC.  
\_\_\_\_ CNS decompression using a 6mm vacurette  
\_\_\_\_ Uterine massage.  
\_\_\_\_ Silver nitrate cauterization  
\_\_\_\_ Monsel's solution applicationFollowing delivery, the patient sat up, dressed herself, and walked to the recovery area.  
Comments: \_\_\_\_\_

AUG/24/2010/TUE 07:25 PM

FAX No. 801 266 7243

P. 027

ELIM STATE OF N. J. - MEDICAID ELIGIBILITY SYSTEM

08/09/10

#24D

12:18:38

4002

MEDICAID INQUIRY

MELIM14

CASE #: 1730039671 PERS #: 49

SCREEN OPT: 074

OR NAME: (L) (F)

DOB:

OR SSN:

\*\*\*\*\*

CASE #: 1730039671 PERS #: 49

PERSON :

PER #: 49 NAME: (L) B (F) D (M) DOB: [REDACTED]  
SSN: [REDACTED] SEX: F MARITAL STAT: S RACE: 2 PR CASE/PERS#: 1730039671 / 49  
BUY-IN STATUS: BUY-IN EFF DATE: LTC CDE: ORIG EFF DATE: 08012010  
ALIEN TYPE: DOE: CHNG DATE: 08062010 SRCE: 517C  
TPL: NO LOCKIN: NO SPEC PEOG: NO MHC: NO CAPITATION: NO  
SUPERVISOR: AA WORKER: 01  
ELIGIBILITY SEGMENTS

CHNG DATE: 08062010 SRCE: 517C

EFFECT DATE	TERM DATE	ADD CDE	TRM CDE	PGM STA	CTY SUPVN	CTY RESID	EXT TYP	PREG DUE DATE
08012010		01		410	017	17		

ENTER = PROCESS CLEAR = END PF1 = MAIN MENU PF2 = INQUIRY MENU  
PF3 = REFRESH PF5 = SCROLL FORWARD PF6 = SCROLL NEXT SSN



AUG/24/2013/TUE 07:25 PM

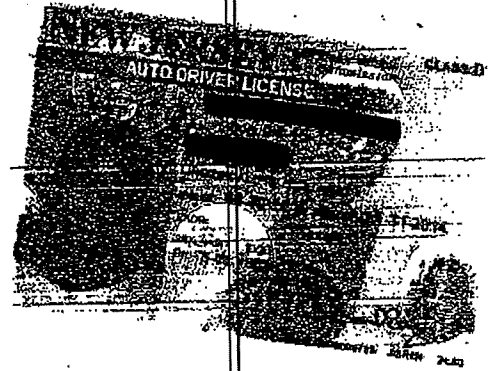
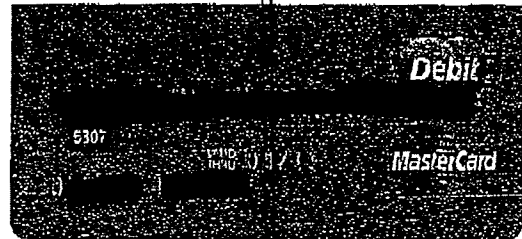
FAX No. 801 266 1243

P. 028

Walmart



Money Network



AUG/24/2013/TUE 07:26 FM

FAX No. 801 266 7243

P. 029

DATE 8/17/10	DESCRIPTION Anesthesia 21.4	TOTAL FEE	PAYMENT CREDITS	ADJ.	BALANCE
-----------------	--------------------------------	--------------	--------------------	------	---------

PATIENT # 7506	NAME [REDACTED] 74927
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## FORM OF PAYMENT:

☒ CASH☐ MONEY ORDER☐ TRAVELER CHECKDISCOUNT: ☐ YES ☒ NO

REASON: \_\_\_\_\_

## CHARGES:

☐ VISA☐ MASTER CARD☐ DISCOVER CARD☐ MAC

## INSURANCE:

☐ PRIVATE/COMMERCIAL

DEPOSIT: \_\_\_\_\_

☐ NJ MEDICAID☐ REFERRAL: GSHP HMO

THANK YOU FOR USING OUR SERVICES !

  
 INTAKE COUNSELOR SIGNATURE

AMERICAN HEALTHCARE SERVICES PC  
 ASHLAND OFFICE CENTER  
 1 ALPHA AVE #27  
 VOORHEES, NJ 08043  
 PHONE: (856) 427-6245

L94QC001423 11/09

DATE 8/17/10	DESCRIPTION TWT @ 10 WKS	TOTAL FEE	PAYMENT CREDITS	ADJ.	BALANCE
-----------------	-----------------------------	--------------	--------------------	------	---------

PATIENT # 1562	NAME [REDACTED] 74883
-------------------	-----------------------------

## FORM OF PAYMENT:

☒ CASH☐ MONEY ORDER☐ TRAVELER CHECKDISCOUNT: ☐ YES ☒ NO

REASON: \_\_\_\_\_

## CHARGES:

☐ VISA☒ MASTER CARD☐ DISCOVER CARD☐ MAC

## INSURANCE:

☐ PRIVATE/COMMERCIAL

DEPOSIT: \_\_\_\_\_

☐ NJ MEDICAID☐ REFERRAL: GSHP HMO

THANK YOU FOR USING OUR SERVICES !

  
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 1 ALPHA AVE #27  
 VOORHEES, NJ 08043  
 PHONE: (856) 427-6245

L94QC001423 11/09

  
 PATIENT SIGNATURE

G-1

gym  
cytotec  
gyn  
24hr  
AD

Lam  
N&DA  
NRA

- \* Asthma Xopenex and inhaler as needed
- \* Seasonal Allergies
- \* Wearing Glasses
- \* High cholesterol
- \* Appendectomy @ 2009

(21.5 weeks)

Driver

609-

ABORTION RECORDPatient Number: DBDate: 8/13/10

8/13/10 ML I have discussed with the patient the abortion she has requested, and I believe she is sufficiently mature and intelligent to understand the nature and consequences of her condition and the procedure. The patient was referred here with laminaria inserted. Her general physical exam was within normal limits.

## Vital Signs:

 B/P: 121/92 Pulse: 87 O2 Saturation: 100 Temp: \_\_\_\_\_

## PRE-EVACUATION EXAM:

Vagina	<input checked="" type="checkbox"/> WNL	<input type="checkbox"/> Other: _____
Cervix	<input checked="" type="checkbox"/> WNL	<input type="checkbox"/> Other: _____ Dilated: _____ cm
Adnexa	<input checked="" type="checkbox"/> WNL	<input type="checkbox"/> Other: _____
Uterus	<input checked="" type="checkbox"/> WNL	<input type="checkbox"/> Other: _____
<input type="checkbox"/> ANT	<input type="checkbox"/> MID	<input checked="" type="checkbox"/> POST SIZE: <u>21.5</u> weeks

Pain Management: Para cervical block: 1% Lidocaine with vasopressin and oxytocin  
☒ Midazolam 2 mg IV ☐ Fentanyl 100 ug IV ☒ ketamine 3 cc IV  
☐ Other \_\_\_\_\_

8/13/10 ML The patient was continuously monitored using pulse oximetry and visual observation. Her medical condition and vital signs ☒ did ☐ did not remain within normal limits at all times during the procedure.

The patient ☐ did ☒ did not, spontaneously deliver the fetus and placenta.

Adjunctive measures used to facilitate the delivery of the fetus, the abortion procedure and/or to stop bleeding:

- ☒ Obstetrical maneuvers
- ☒ Forceps use
- ☒ Sharp curettage of the endometrium
- ☒ Vacuum aspiration of amniotic fluid, blood, parts, etc.
- ☐ CNS decompression using 6mm vacurette
- ☐ Uterine Massage
- ☐ Silver Nitrate cauterization
- ☐ Monsel's Solution application

## Comments:

It did have extra-uterine tissue observed. Procedure immediately stopped and see attached note. Pt transported in stable condition to PACU consented.

#5

## ABORTION RECORD, PAGE 2

Chart Number: AB-10-1562

## Examination of Products of Conception:

- A. Tissue Weight \_\_\_\_\_ gm
- B. POC grossly identified:
- |          |                              |                             |                            |
|----------|------------------------------|-----------------------------|----------------------------|
| Villi    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> ? |
| Sac:     | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> ? |
| Parts:   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> ? |
| Decidua: | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> ? |
- C. Fetal Foot length: \_\_\_\_\_ mm
- D. Final Estimated Gestation: \_\_\_\_\_ wks. LMP: \_\_\_\_\_
- E. ☐ Repeat urine HCG showed:  
☐ Tissue to Lab  
☐ Quantitative Serum B-HCG sent to Lab  
☐ Ectopic Pregnancy Fact Sheet given to patient

## Comments:

Sent to ER via POPt. Should seek follow-up care: ☐ Routine F/U in 2 weeks Other: FollowMEDICATIONS ORDERED☐ MicroRhogam ☐ Rhogam ☐ OtherMEDICATIONS DISPENSED

- ☐ Doxycycline 100 mg po BID x 6 days
- ☐ EES 250 mg po QID x 7 days
- ☐ Amoxicillin 1.5 gms po 6 hr post-AB
- ☐ Acetaminophen 100 mg po PRN
- ☐ Other: \_\_\_\_\_

MEDICATIONS PRESCRIBED

- ☐ Ibuprofen 400-800 mg po TID x 3 days PRN cramping
- ☐ Ferrous Gluconate 300 mg po BID x 90 days, begin completion of post-op antibiotics
- ☐ Metronidazole 500 mg 1 tablet po BID x 7 days
- ☐ Methergine 0.2 mg po TID x 3 days
- ☐ Other: \_\_\_\_\_

## Additional Comments:

Physician's Signature: [Signature] 8/13/10

Recommendation  
of Hospital  
Physicians

Page 1 of 3

GRACE MEDICAL SERVICES

PROGRESS NOTE

CHART NUMBER: XB - 10 - #1502

PATIENT NAME: J. [REDACTED] B. [REDACTED]

It is an 184/0 African American female  
G1P0 @ 21.2 weeks gestation by U.S.

Pt agreed to termination of pregnancy  
w/ laminaria. At approximately 1:00 pm  
Pt taken for procedure. Pre-O2

vitals were stable @ 127/92 B/P, Pulse 87  
& O2 saturation 100%.

Pt given sedation as per protocol, 2mg  
Midazolam, 100 ug fentanyl and 1 cc Ketamine  
IV w/o complication. It was monitored

via Pulse oximetry, Visual observation  
by physician & staff & B/P measurement.  
Pt vital signs throughout procedure were  
stable.

After removal of laminaria & administration  
of local anesthesia 2 cc of 1% Lidocaine  
and 5 Units Pitocin and 5 Units  
Oxytocin, 4 tablets of Ecogest Misoprostol  
administered rectally Pt's Membranes

/page 2 of 4

## GRACE MEDICAL SERVICES

## PROGRESS NOTE

CHART NUMBER: XB-13-#1562PATIENT NAME: L [REDACTED] B. [REDACTED]

were ruptured + amniotic fluid drained w/o complication. Additional Ketamine administered prior to D+E.

D+E procedure commenced using Brier Forceps w/o complication. After removal of fetal arm/leg + part of head, extra uterine tissue was observed. Procedure immediately stopped, vitals began monitored and stable.

Dr. Kelaj informed staff to start IV, check vitals and call Union Hospital ER for immediate transport. Pt

family informed of possible complication and need to transport to Union Hospital ER & bypassing. Family agreed to follow

Dr. Kelaj & staff together + Pt. w/ FOX. During transport, vitals were stable.

@ 1300h, Pula 85% & sat 100%.

ER staff. Doctor was on notice of leaving Pt. (Dr. Gill, MD).

#6

8/17/13

## GRACE MEDICAL SERVICES

PROGRESS NOTECHART NUMBER: AB - 10 - #1502PATIENT NAME: D. [REDACTED] B. [REDACTED]

An ER, Dr. Gill was given report in person by Dr. Kelg. Pt. was then further stabilized and signed in by family. (i.e. Insurance info given by mother & demographics by boyfriend.) Dr. Kelg was informed within the hour by Dr. Gholami, OB/GYN physician. Dr. Kelg informed pt. stable but needed transport to John's Hopkins for surgery & explanation regarding. Dr. Kelg followed up with Dr. Gholami again @ approximately 2:27 pm. Pt. listed as stable and transport pending in next 5-10 minutes.

End Note

Quincy man (8/13/10) (14:45)