Date: ______________________

Home Phone (   ) _________________________
Cellular Phone (   ) _________________________

REGISTRATION FORMS

Patient ____
Last Name   First Name   Middle
Responsible party (if minor) ____________________________________ Relationship __________________________

Street Address ____
City _____________________________ **State** ________________ **Zip Code**____________________

Sex: [ ] Female   [ ] Male   **Age**: ___________   **Birth date**: ____________________   [ ] Single   [ ] Married [ ] Widowed
[ ] Separated   [ ] Divorced

EMAIL ADDRESS: ____________________________________@________________
SOCIAL SECURITY #: ____________________________________ **Education Level:** _____________________________

EMPLOYMENT INFORMATION

Patient's Employment___________________________________ **Occupation;**____
Work Phone __________________________________ Ext. _______

Primary Physician: ____**Office Phone:** ______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____
Contract ID #_______________________ Group # ________________________ Insured______________ Eff date: ____________

EMEGENCY CONTACT

Spouse/Partner: ____ **Date of Birth**: ____________________
Spouse/Partner Phone: __________________________ **Work Phone:** ______________________
Spouse Email: ____
Spouse Employment: ____

Emergency/Alternate contact____ **Phone:** ______________________
Relationship to Patient: __________________________________ **Alt Phone:** ____________________

CHILDREN INFORMATION

Child Name	**Gender**	**Birthdate**
(1) ________________________________	**F ( ) M ( )**	_____________________
(2) ________________________________	**F ( ) M ( )**	_____________________
(3) ________________________________	**F ( ) M ( )**	_____________________

MEDICATION ALLERGIES

Allergies: ______________________________ **Reaction:** ____
Preferred Pharmacy: ____ **Phone:** ______________________________

GENERAL CONSENT AND AGREEMENT

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

It is the responsibility of healthcare providers to inform childbearing families of their options in birth settings and the risks and benefits of choosing any of those settings. The settings chosen must be one considered sage and satisfying in meeting the needs expressed by the family.

The options for care in pregnancy and birth that we offer are in our free-standing birth center or hospital. All care is provided by a team consisting of certified nurse midwives, registered nurses, obstetricians and gynecologists. When you register for care, you can expect that your prenatal care, birth and postpartum care will be provided by the nurse midwives as needed. Should problems arise which require medical care, your care may be managed collaboratively by the CNMs and obstetricians or the obstetrician may take over your care.

It is the policy of **Maternity Options of Miami** that the childbearing family may choose an out-of-hospital birth if the expectant mother has:

1. An uncomplicated medical and obstetrical history, and
2. A present pregnancy that is proceeding normally, and
3. If the expectant mother and her family have chosen to assume the added responsibility 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 exist when birth occurs in a hospital that do not exist in a Birth Center. Likewise, certain hazards exist when birth occurs in a Birth Center that do not exist in a hospital. Studies of the Birth settings have indicated that the outcomes for low-risk women are comparable when birth occurs in our Birth Center. Our Birth Center staff 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. Non-reassuring FHR patterns – decreases in the fetal heart rate that may indicate the baby is being stressed.
2. Difficult neonatal transition – baby does not breathe immediately after birth and required resuscitation (breasting for baby with bag and mask).
3. Maternal hemorrhage – excess blood loss.
4. Pre-eclampsia or toxemia – pregnancy-induced high blood pressure that is associated with impaired liver and kidney function and may cause seizures.
5. Amniotic fluid embolism – a drop of amniotic fluid enters the mother's bloodstream causing blood clots in vital organs such the brain and lungs and can results in cardiac arrest.
6. Uterine rupture – uterus splits open

Complications Involving the Placenta:

1. Placenta Previa – placenta partially or completely covers the opening of the uterus; can cause hemorrhage and requires cesarean delivery.
2. Placenta abruption – placenta separates from wall of uterus before baby is born.
3. Retained placenta – all or part of the placenta remains inside the uterus.

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 Baby:

1. Pre-Labor rupture of membranes – amniotic fluid sac breaks prior to onset of labor and labor does not spontaneously begin.
2. Cord prolapse or cord compression – 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. Intrauterine Fetal Demise/Stillbirth – baby dies in mother's uterus before birth.
6. Meconium-stained amniotic fluid – baby has bowel movement inside uterus; if has solid particles can cause lung problems.
7. Congenital anomalies – birth defects
8. Immaturity or post-maturity – baby is born prior to 37 weeks or after 42 weeks.
9. Hyperbilirubinemia – jaundice (yellow skin) in newborn caused by too much bilirubin in baby's body after birth; can cause brain damage if it is too high.

CONSENT AND AGREEMENT

1. **Physical Examination**: I authorize the nurse-midwife and their medical consultants and nurses 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 of both vaginal and rectal, with and without instruments; (60 obtaining rectal, vaginal and cervical specimens, including Pap Smear.

   I understand that, even when the above are properly and correctly done, there is a potential of 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 it.

2. **Authority to Treat:** I authorize the nurse-midwives, their medical consultants and nurses to treat, administer and provide as necessary or available to me and the 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 medication 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 I the office, Birth

Center, my home, and elsewhere, including ambulance and hospital. I grant to the nurse-midwives, their medical consultants and nurses 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 the Birth Center or home.

3. **Early Transfer:** I understand that the Birth Center 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 judgement of the nurse-midwives, the management of my pregnancy shall be transferred to the physician of my choice or my care will be managed collaboratively by the CNMs and their obstetrical consultants. I understand that, under certain circumstances, I will be ineligible for a Birth Center birth.
4. **Complications of Pregnancy and Birth:** I have read and understand the list of complications of pregnancy and birth and discussed them with the nurse-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 guarantee 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 and/or independent study. This includes preparation to perform emergency childbirth should labor proceed rapidly. I will prepare myself, to the extent possible, to go through birth without sedatives, tranquilizers or anesthesia.

6. **History:** I understand that the safety of care by the nurse-midwives, their consulting physicians and of birth center's births depends upon my medical history and the information which I provider about myself. I affirm that such information is, and will be, accurate and complete to the best of my knowledge.

7. **Research:** In an effort to support the development of Birth Center and nurse-midwifery care, I consent to the sharing information from record statistical reporting and the information which I provider about myself. I consent to the disposal of the cord blood, cord and placenta.

8. **Transfer to the Hospital:** I agree to transfer from the Birth Center to the hospital in the event of any circumstances in which the nurse-midwife feels that hospital care is required or advised. In the event of an emergency, however, I will be transferred to the hospital and according to stand procedures. Depending upon the nature of the complication, my care at the hospital will be managed by either the nurse- midwife in collaboration with the obstetrician, or exclusively the obstetrician. All hospital and physician expenses incurred at the 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 provider all normal postpartum care, include a home visit within 24 hours after birth for selected families. It is my obligation to arrange Pediatric care immediately upon discharge of the infant from the Birth Center. I understand it is my obligation and responsibility to make an appointment within 24-48 hours for the initial Newborn Assessment required by the State of Florida and for any management of the newborn.

I understand that childbirth and the early postpartum period are stressful times for families, both physical and emotionally. I agree to provider for necessary assistance during the birth and the first week postpartum. This includes obtaining a support person for older siblings 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 birth at **Maternity Options of Miami.**

I have read all of the information contained in this Informed Consent and have had full opportunity to ask questions. All of my questions have been answered to my complete satisfaction. I understand the policies and limitations of the nurse-midwives at Maternity Options of Miami and in the hospital. I accept my responsibilities in regard to the pregnancy, birth and postpartum period and agreed to share the responsibilities for the outcome of this birth.

Date: ________________________

____
MOTHER **Print Name**

Date of Birth: _____________

____
Signature

Date: ________________________

____
FATHER/PARTNER **Print Name**

Date of Birth: _____________

____
Signature

For office use only

Date: ________________________ ____
Maternity Options of Miami, Representative

NOTICE OF PRIVACY PRACTICE - PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. **Maternity Options of Miami LLC** provides you this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations
Maternity Options of Miami, LLC, has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
Maternity Options of Miami, LLC reserves the right to change the Notice of Privacy Policies
The patient has the right to restrict the uses of their information but **Maternity Options of Miami, LLC** does not have to agree to those restrictions
The patient may revoke this Consent in writing at any time and all future disclosures will then cease
Maternity Options of Miami, LLC, may condition treatment upon the execution of this Consent

______________________________	______________________________	_____/____/_____
Printed Name	Signature	Date

In front of ___________________________________
Printed name – Practice representative

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative mean, such as sending correspondence to the individual's office instead of the home.

I wish to be contacted in the following manner (check all that apply):
(Quisiera que me contacten de esta manera (marque todo lo que appliqué)

[ ] Home Telephone______________________ (Al telefono de casa)
[ ] O.K to leave message with detailed information (Se puede dejar mensajes con detalle)
[ ] Leave message with call back number only

[ ] Cellular __________________________
[ ] O.K. to leave message with detailed information(Se puede dejar mensajes con detalle)
[ ] Leave message with call-back number only (dejar mensaje con numbero solamente)

[ ] Work Telephone____________________ (Telefono de trabajo)
[ ] O.K. to leave message with detailed information(Se puede dejar mensajes con detalle)
[ ] Leave message with call-back number only (dejar mensaje con numbero solamente)

____________________________________ ______________________________
PATIENT SIGNATURE (Firma de paciente) **Date** (Fecha)

____________________________________ ____________________
PRINT NAME (Escriba su nombre) **Date of Birth** (Fecha de nacimiento)

MAY WE LEAVE A MESSAGE IN YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE?
(PODREMOS DEJARLE UN MENSAJE EN SU MAQUINA TELEFONICA O CORRE ELECTRONICO?)
Yes [ ] NO[ ] N/A [ ]

MAY WE CONTACT YOU AT WORK? (PODEMOS LLAMERLE AL TRABAJO?)
Yes [ ] NO [ ] N/A [ ]

MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMBER?
Yes [ ] NO [ ] N/A [ ]
(NOS AUTORIZA DISCUTIR INFORMACION MEDICA CON SU ESPOSO O ALGUN FAMILIAR?)

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Maternity Options of Miami, LLC, for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fee should assistance become necessary. The undersigned agrees, whether she/he signs as parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, she/he hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
El/La suscrito(a) autoriza que, toda la informacion medica accesaria para procesar cualquiera de mis reclamos a mi compania de seguro ea puesta a disposicion de esta. Asi mismo autorizo el pago de mis beneficios directamente a Women's Healthcare of Kendall, LLC. Entiendo y accepto que, independiente de mi condicion de asegurado(a), soy totalmente responsible de mi cuenta por los servicios recibidos en esta oficina. Si acaso esta cuenca fuese enviada a un servicio de cobranza, todos los gastos que se irigen de este recurso legal son tambien de mi responsabilidad. El/la suscrito(a) consiente que al firmar como padre, esposo(a), fiador, guardian o paciente, assume la responsabilidad y obligacion por cualquier balance pendiente que derive a causa de tratamiento medico a dicho paciente. En caso de que la cuenta fuese referida a un bogado(a), el/la suscrito(a) pagara dichas cuentas legales y asumira costos de coleccion.

SIGNATURE (FIRMA) ____________________________________ DATE ______________________________

NAME (NOMBRE) ____

E-MAIL CONSENT FORM

Patient Name: ____ Date: _______________________

Patient E-mail address: ____ Phone: ______________________

1. **RISK OF USING EMAIL TO COMMUNICATE WITH OUR PROVIDER.**

You provider offers patients the opportunity to communicate by e-mail. Transmitting patient information b e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. **CONDITIONS FOR THE USE OF E-MAIL:**

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidential of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentions misconduct. Thus, the patient must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient medical record. Because they are part of the medical record, other individual authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is patient' responsibility to follow-up and/or scheduled an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS.**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes to his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the Patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider

E-MAIL CONSENT FORM

4. TERMINATION OF THE E-MAIL RELATIONSHIP.

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and condition set forth above or otherwise breached agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instruction outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may had were answered.

Patient Name (print) ____

Patient Signature ____ Date ______________________

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designer and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees relating to or arising from any information loss due to technical failure, my use of the
Internet to communicate with the Providers, and any breach by me of these restrictions and conditions.

Patient Name (print) ____

Patient Signature ____ Date ______________________

HOLD HARMLESS CLAUSE

I, _____________________________________ do understand that my midwife has an agreement with Maternity Options of Miami, LLC.

Furthermore, I do understand that should any complication or unforeseen events occur during a prenatal visit, labor, birth, or a postpartum visit that I will hold harmless Maternity Options of Miami, LLC for any penalties, lawsuits or liabilities that may occur.

Print Patient Name: ____

Patient Signature: ________________________________ Date: _______________

MOM Representative Signature: _________________________________

Date: _______________________

NITRIOUS OXIDE FOR LABOR INFORMED CONSENT

I understand the risks and benefits of breathing nitrous oxide for labor or other procedures and I wish to use this form of controlled analgesia. I understand that this form of pain management may not remove all sensation or discomfort.

I understand that there are potential side effects of nitrous oxide, which most commonly include dizziness and nausea. If I use nitrous oxide, I understand that I must have a support personal present with me at all times. If I wish to stop using nitrous oxide at any time during labor or another procedure, I may voluntarily discontinue use immediately. I will then inform the midwife of the decision.

I understand that there is a fee which will be charged for the set-up of the nitrous equipment as form of analgesia and my insurance will not be billed.

I understand that using nitrous oxide may make me feel unsteady for brief periods of time. If I need or want to change positions or walk around while using nitrous oxide, I will do so only with the assistance form a support person, midwife or nurse. I also understand that if I am using nitrous oxide, I may only use the birth pool with direct supervision by a staff member or a member of my support team.

I agree to hold the mask on my own and I will not allow others to hold the mask to my face or utilize any other form of external support (pillow, straps, etc.) to maintain the mask on my face.

I will not allow anyone other than myself to use the mask and understand that anyone observed attempting to, or using the mask will be asked to leave the room. Nitrous oxide would then no longer be available for my use.

I understand there could be theoretical risks to nitrous oxide, as well as other pain-relieving medications used during pregnancy. I understand that nitrous oxide has been used throughout the world for labor pain control for many decades and is considered safe.

I understand that signing this form means that this option is available to me, but does not obligate me to use this pain relief option. Should I consider using nitrous oxide, I will inform Maternity Options of Miami, LLC before my 32 weeks of gestation and sign the financial agreement. I understand that payment is non-refundable for the set-up of the equipment.

I understand my request to use of nitrous oxide is on a first come/first serve basis. There is no guarantee that it will be available for my specific use.

Patient Printed Name Signature Date

MOM Representative Signature Date

Consent to Deliver In a Birth Center

1. I have voluntarily chosen to deliver my child at **Maternity Options of Miami, LLC, a Birth Center.** I made this decision after being informed that in the course of childbearing, which is a normal human function, medical problems may be unpredictable and suddenly arise which may present a risk to myself and the unborn child. I understand that the birth center is not a hospital and has no facilities to do emergency cesarean sections, has no intensive care units for newborns or adults, and does not provide general anesthesia or epidurals. I am aware that the practice of medicine, midwifery, and nursing are not exact sciences, and I acknowledge that no guarantees or assurances have been made to me concerning the results of the treatments, examinations, and procedures to be performed. I hereby release the birth center and the staff from all liability from complications which may occur during the course of my labor and delivery of my child as a result of my choice to use the birth center.

2. I am also aware of the benefits of natural childbirth relating to avoidance of potential injury resulting from invasive procedures, anesthesia, or surgical intervention.

3. I am aware that the clinical staff who will provide prenatal services and attend me during labor and delivery are: Pauline R. Theobalds, CNM and are duly licensed to practice in the state of Florida.

4. Should any medical problems arise during my labor, I am aware of the medical necessity for and hereby consent to my immediate transfer to the hospital for further care. If this should be necessary, I understand that the rules and regulations of the hospital must be adhered to.

5. Should any medical problems related to the well-being of my newborn infant arise after delivery, I am aware of the necessity for and hereby consent to the immediate transfer of the infant to: **Baptist Hospital of Miami** for further care.

6. I understand that all hospital and medical expenses incurred as a result of complications shall be my obligation and are not included in the financial arrangements with the birth center.

____

Signature of Patient

____

Date

____

Witness

Waterbirth & Hydrotherapy in Labor Informed Consent

The use of water is one of the many options available for your labor and birth. Before planning to give birth in the water, however, there are some things you should know. Please review the statements below and initial that you have read and understand each line.

Giving birth underwater is generally considered safe and is popular in areas of the US and many other countries. However, medical research is limited as to the effects of waterbirth on mother and infant. The proposed benefits of waterbirth include less pain, improved relaxation, decreased need for episiotomy, lower blood pressure, decreased anxiety and often a faster labor. As stated before, not all of these benefits can be supported by research. The proposed risks of waterbirth are believed to include dehydration of the mother, an increased chance of infection, and increased chance of bleeding, slips/falls while getting out of the tub and overheating. Possible risks specific to baby include possible inhalation of water in the lungs, overheating, and loss of body heat. In 0.15 to 1.5% of all births, underwater or not, there is some risk of a difficult delivery of the baby's shoulders. Shoulder dystocia is not necessarily increased by waterbirth. However, managing shoulder dystocia may be more difficult in the tub. You may be asked to leave the tub for reasons determined by your midwife. These might include elevated temperature, changes in the baby's heart rate, bleeding, a need for an episiotomy, excessive contamination of the water and/or difficult labor. Other complications not listed here might arise and necessitate leaving the tub. After birth the baby may remain on your chest or your baby's condition may require that his/her cord be clamped and cut to facilitate resuscitation efforts.

_____ I have been given an opportunity to fully discuss and understand the risks and benefits of underwater birth compared to other means of childbirth.

_____ I am aware that the practice of midwifery carries no guarantees regarding the outcome of underwater birth of my baby.

_____ I understand that I may be asked to leave the tub, and I agree to exit if requested.

_____ I understand I may need to lift myself from the water for examinations, listening to the baby, delivery of the placenta and any emergency.

_____ I understand that I must read and sign this document to participate in a waterbirth or use hydrotherapy in labor.

_____ I have read and fully understand the provided information. All of my questions have been answered by my midwife to my satisfaction. I understand that approval of my plan to attempt a waterbirth is based on information available as of this date and may require change as my pregnancy or labor progresses.

Patient Printed Name	Signature	Date

MEDIA RELEASE

Sometimes our families like to share birth announcements, stories, pictures and videos in our office or on social media. We NEVER take pictures or videos of our clients without your request or express consent. This form gives us permission to only share items that you share with us. You can decline posting or sharing of any item at any time. This form releases **Maternity Options of Miami, LLC, ("MOM")** and its representatives, employees, managers, members, officers, subsidiaries, subcontractors, owners and directors from all claims and demands arising out of or in connections with any use of said "materials" including without limitation all claims for invasion of privacy, infringement of my right or publicity, defamation and any other personal and/or property rights.

Please choose one of the following statements, then sign and date this form:

_____ I grant permission to **MOM** to post my photo, story, photo or other item to the **Maternity Options of Miami, LLC, ("MOM")** website, Twitter account, online learning materials, slideshows and Facebook account. MOM will not use my name or my child's name without my express permission.
I understand that no sums whatsoever will be due to me as a result of the use and/or exploitation of the materials or any rights therein.

_____ I decline the release to use any items, and *I will **not** share* any birth announcements, photos or other materials with **MOM.**

____

Client Printed Name **Signature** **Date**