Community Outreach MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

Prenatal Care Program
Prenatal Care Consent

Patient Name: _____ DOB: _____ Date: _____

Consent for Prenatal Care

1) I hereby agree and consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I hereby agree and consent to be given prenatal care and guidance by the medical staff of Community Outreach Medical Center (COMC), Prenatal Care Program, and agree and authorize that any record concerning examination and treatment may be released to University Medical Center of Southern Nevada (UMC) for their official use only. Further, I agree that any records of my examination or treatment are to remain the property of COMC and may be released according to federal and state laws for treatment, payment and operations.
2) I hereby agree not to hold COMC or its personnel responsible for any condition resulting from any services received.
3) It is understood that the services performed by COMC staff will require a fee from all prenatal clients.
4) I understand and agree to assume ALL HOSPITAL AND PHYSICIAN CHARGES INCURRED OUTSIDE OF COMC which have not been specifically ordered or authorized by clinic staff or for which program funds are not available.
5) I understand I am required to keep clinic appointments. If I miss three (3) consecutive clinic appointments, I may be discharged from the Prenatal Care Program.
6) I further understand that I am required to follow all medical guidance and/or referrals from the clinic medical staff, such as genetic counseling, colposcopy procedures, sonograms, etc. If I refuse to comply with these requirements, I will sign a "Refusal to Permit Medical Treatment" form. As a consequence of my refusal to follow medical guidance, I may be referred to UMC for the remainder of my prenatal care and discharged from the Prenatal Care Program at COMC.
7) In the event that I choose to seek services elsewhere, or if I am discharged from the Prenatal Care Program for failure to follow medical guidance, as stated above, I understand and agree to pay all costs incurred by me through COMC for prenatal care, i.e. laboratory fees, ultrasound, etc.
8) I understand I am responsible for payment of prescriptions given to me by the Physician/Nurse Practitioner.
9) I understand if I am determined to be medically high-risk by the Physician/Nurse Practitioner during my enrollment in the COMC Prenatal Care Program, I will be referred to UMC's High-Risk Program with my records and will be responsible for any expenses incurred therein.
10) As a patient of the Prenatal Care Program at COMC, I am required to keep scheduled appointments and follow the medical guidance of my Physician/Nurse Practitioner. I understand that my Physician/Nurse Practitioner cannot safely manage my pregnancy and delivery if I fail to attend scheduled appointments or refuse treatments or laboratory tests.
11) I understand that I may no longer be eligible for the Prenatal Care Program at COMC if I miss three (3) consecutive scheduled appointments or if I refuse to follow medical guidance.

Consent for Delivery

As a patient of the Prenatal Care Program of COMC, I have been informed and understand the options for delivery at UMC. I also understand that all medical bills incurred while at UMC are separate fees not associated or included in the Community Outreach Medical Center Prenatal Care Program. I am aware I must register at UMC at twenty (20) weeks of pregnancy in order to enroll in a payment plan with the Baby Steps Program at UMC for my delivery. I also understand that UMC Residents are available at all times for any emergencies that may occur.

I hereby agree and consent to be given prenatal care at COMC and to have my delivery care managed by UMC.

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Patient Signature or Legal Representative *Date*