INFORMED CONSENT FOR PREGNANCY, LABOR AND DELIVERY, AND POSTPARTUM CARE

_______ I have been informed of, understand, and agree to accept the risks of pregnancy, labor and delivery, and postpartum.

_______ I understand that I have the option to attend educational classes on pregnancy, labor, and delivery to further my understanding.

_______ I agree to medical care for pregnancy, labor and delivery, and postpartum care by Fresno Women's Medical Group, Inc., and the physicians with whom they share call.

____ ____________
Printed Name DOB

____ ____________
Signature Date