



SOUTH COAST UROGYNECOLOGY WELCOMES YOU

...and thanks you for selecting us for your healthcare needs. We are dedicated to providing you with the best personalized healthcare and solutions. To help us do this, please fill out this form completely in ink. If you have any questions or need help, please ask us. We will be happy to help you. Complete this form prior to your visit if possible.

PERSONAL INFORMATION

Today's date _____ Social Security _____ Birthday _____
 Name _____
 Address _____
 City/State/Zip _____
 Age _____ Single Married Divorced Separated Widowed
 Employer _____
 Referred By _____ Primary Physician _____
 Primary Physician Address _____
 Primary Physician Phone # _____ Fax# _____

TELEPHONE INFORMATION

Home Phone _____ Work Phone _____ Ext. _____
 E-Mail _____ Cell Phone _____

(We prefer and encourage e-mail communication for speed and efficiency)

When is it the best time to reach you? Mon Tues Wed Thurs Fri Sat Sun
 Where do you prefer to receive calls? Home Work Cell Phone
 Emergency Contact _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____

RESPONSIBLE PARTY

Who is responsible for this account?
 Name _____ Relationship to Patient _____
 Address (if different from patient's) _____
 City/State/Zip _____
 Social Security # _____ Drivers License # _____ Birthdate _____
 Employer _____ Occupation _____
 Home Phone _____ Work Phone _____

INSURANCE INFORMATION

| Primary Insurance | Secondary Insurance |
|-------------------------------|-------------------------------|
| Name of Insurance _____ | Name of Insurance _____ |
| Subscriber # _____ | Subscriber # _____ |
| Group # _____ | Group # _____ |
| Name of Insured _____ | Name of Insured _____ |
| Relationship to Patient _____ | Relationship to Patient _____ |
| Insured's Birthdate _____ | Insured's Birthdate _____ |
| Soc. Sec. # _____ | Soc. Sec. # _____ |

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING:

I hereby assign all medical/surgical benefits to **South Coast Urogynecology, Inc. /Dr. Red Alinsod** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement shall be as valid as the original.

SIGN HERE _____ DATE _____



SOUTH COAST
PHYSICIANS

Red Alinsod M.D.

PAYMENT POLICY v2.1

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your **coverage.**
2. **Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.
6. **Coverage.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** We may charge a \$25 fee for missed appointments not canceled within 24 hrs. These charges will be your responsibility.
9. **Bounced checks.** Please be advised there is a \$25 fee for any bounced or returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party _____ Date _____

Print Name _____



Red M. Alinsod, M.D.,
FACOG, ACGE

red@urogyn.org
Toll Free (877) 4-UROGYN
Mon (949) 499-5311
Fax (949) 499-5312

Payment Policy for Aesthetic Surgery

Dr. Alinsod is the leading surgeons in his field of expertise and takes great pride providing quality and confidential care. Patients are exceptionally valued and provided extensive consultation time with both Dr. Alinsod and our patient liaison, enabling all questions and concerns to be addressed well in advance of scheduled surgery.

As you can imagine, surgical slots are at a premium. A great deal of thought has been given for evaluation, preparation, surgery time, and staffing needed for each procedure. In consideration for Dr. Alinsod's time, staff members, and fellow clients, we have an unwavering financial policy.

A 50% deposit is required at the time of scheduling surgery. This allows us to block the time needed for your surgery. The remaining balance is due one week prior to surgery. All fees must be received one week prior to surgery. A nonrefundable 25% of deposit will be retained for a cancelled surgery that is not rescheduled with Dr. Alinsod.

We accept cash, all major credit cards, and cashiers check. A 5% discount will be given for cash payments. Personal checks are not accepted. We provide several financing options and would be happy to discuss those with you.

Please note, additional surgical procedures cannot be added on the day of surgery unless payment in full has been received.

Sincerely,

Red M. Alinsod, M.D., FACOG, FACS, ACGE
Urogynecology & Reconstructive Pelvic Surgery

I agree and understand the SCU Payment Policy for Aesthetic Surgery.

Patient Signature

SCU Representative

Date



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Fax (949) 499-5312

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. This will lower our billing costs. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will charge you only the portion of the insurer-determined payment not paid by the insurer. We will not do "balance billing," which is asking you to pay the difference between our normal fee and the insurer's normal payment. We will accept your insurer's allowable billing amount. This policy may not apply if you are a cash-paying patient.

If you do not have a credit card we will require a lawyer-style "retainer" of \$500 that is held in escrow and used to pay receivable amounts as they come due. Co-pays due at the time of the visit will, of course, still be due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask us.

Our office will also have a "No-Show" fee of \$25 that is charged to your credit card if appointments are missed without a 24-hour notice. Our appointment slots are at a premium and we truly value the time we are able to spend with you.

Sincerely,

Red M. Alinsod, M.D., FACOG, FACS, ACGE



SOUTH COAST UROGYNECOLOGY

AESTHETIC HISTORY AND PHYSICAL

Date: _____

Patient Name _____ Medical Record # _____

Age _____ Date of Birth _____ Last Menses (1st Day) _____

Pregnancies _____ Births _____ (Vaginal _____ Caesarean _____) Miscarriages _____ Abortions _____

Address: _____

Phone (Home) _____

Allergies: None (NKA)
 Yes _____

Phone (Work) _____

Phone (Cell) _____

Phone (Fax) _____

Email _____

How did you hear about us? Referred by: _____

CHIEF COMPLAINT (Why you want to see the doctor today?)

INTERESTED IN AESTHETIC VAGINAL SURGERY

- | | |
|---|---|
| <input type="checkbox"/> I want aesthetic vaginal surgery | <input type="checkbox"/> I have had difficult births |
| <input type="checkbox"/> My labia are larger/looser than what I want | <input type="checkbox"/> My vagina feels too loose inside |
| <input type="checkbox"/> I do not like the way my labia looks | <input type="checkbox"/> I have decreased sensations |
| <input type="checkbox"/> My labia rub, tug, and pull on my clothing | <input type="checkbox"/> I feel pelvic heaviness/pressure |
| <input type="checkbox"/> I am unable to wear the type of clothing I want | <input type="checkbox"/> Sex is uncomfortable/unpleasant |
| <input type="checkbox"/> I have had unflattering comments about my genital region | <input type="checkbox"/> I rely on my appearance at work |
| | <input type="checkbox"/> I am interested in G-Spot augmentation |

INTERESTED IN VASER LIPOSELECTION AND BODY CONTOURING

- | | |
|--|--|
| <input type="checkbox"/> Upper Abdomen | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Lower Abdomen | <input type="checkbox"/> Upper Thighs/Saddlebags |
| <input type="checkbox"/> Flanks and Love Handles | <input type="checkbox"/> Inner Thighs |
| <input type="checkbox"/> Mons Pubis | <input type="checkbox"/> Knees |

INTERESTED IN AESTHETIC LASERS/IPL/RADIOFREQUENCY TREATMENTS

- | | |
|--|--|
| <input type="checkbox"/> I want Hair or/and Vein reduction | <input type="checkbox"/> I want Pelleve Skin Tightening |
| <input type="checkbox"/> I want to remove brown spots/sun damage | <input type="checkbox"/> I want Botox/Skin Fillers |
| <input type="checkbox"/> I want to remove red blood vessels | <input type="checkbox"/> I want Stretch Marks/Scar Reduction |
| <input type="checkbox"/> I want Fotofacial/Fraxel | <input type="checkbox"/> I want Facials/Silk Peel/Reiki Tx |
| <input type="checkbox"/> I want an Aesthetician Consult | <input type="checkbox"/> I want info on Skin Care Products |

Patient Name _____

EXAMINATION:

Constitutional: Ht _____ Wt _____ BMI _____
Temp _____ BP _____ Pulse _____ Respiration _____

| | Normal | Abnormal | Drawing |
|---------------|---------------------------------|----------|---------|
| Appearance: | [] | [] | |
| HEENT: | [] | [] | |
| Heart: | [] | [] | |
| Lungs: | [] | [] | |
| Breast/Chest: | [] | [] | |
| Abdomen: | [] | [] | |
| Extremities: | [] | [] | |
| Skin Lesions | <input type="checkbox"/> None | _____ | |
| Lymph Nodes | <input type="checkbox"/> Normal | _____ | |
| Hernias | <input type="checkbox"/> None | _____ | |
| Other | _____ | | |

Measurements:

IMPRESSION:

PLAN & RECOMMENDATIONS:

DISCUSSIONS:

- | | |
|---|--|
| <input type="checkbox"/> Risks/Benefits/Options of surgery/procedures | <input type="checkbox"/> Review Website Videos and Articles |
| <input type="checkbox"/> Meet with Finance/Business Office | <input type="checkbox"/> Review Pre and Post Op Instructions |
| <input type="checkbox"/> Meet with Scheduler | <input type="checkbox"/> Discuss/Schedule Pre and Post Op Photos |
| <input type="checkbox"/> Read Educational Materials | <input type="checkbox"/> Skin care and Sun Exposure |

FOLLOW UP ___Days ___Weeks ___Months ___Year/s

PATIENT SIGNATURE _____

DOCTOR SIGNATURE _____

DATE _____

Patient Name _____

PRE-OP NOTE: The surgical case was discussed with the patient at length. The surgery/s is/are:

- | | |
|---|---|
| <input type="checkbox"/> Suburethral Sling, Cystoscopy | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Anterior Repair, Paravaginal Repair | <input type="checkbox"/> Lysis of Adhesions |
| <input type="checkbox"/> Posterior Compartment Repair | <input type="checkbox"/> Fulguration of lesions |
| <input type="checkbox"/> Enterocele Repair | <input type="checkbox"/> Cystectomy |
| <input type="checkbox"/> Vaginal Vault Suspension | <input type="checkbox"/> LUNA |
| <input type="checkbox"/> SSLS | <input type="checkbox"/> Ureteral Dissection |
| <input type="checkbox"/> PIVS | <input type="checkbox"/> Laparotomy |
| | |
| <input type="checkbox"/> TVH, Total Vaginal Hysterectomy | <input type="checkbox"/> Bilateral Salpingo-oophorectomy |
| <input type="checkbox"/> TAH, Total Abdominal Hysterectomy | <input type="checkbox"/> Unilateral Salpingo-oophorectomy |
| <input type="checkbox"/> LSH, Laparoscopic Supracervical Hys. | <input type="checkbox"/> Ovarian Cystectomy |
| <input type="checkbox"/> LAVH, Laparoscopically Assisted Vaginal Hysterectomy | |
| <input type="checkbox"/> LH, Laparoscopic Hysterectomy | |
| | |
| <input type="checkbox"/> Labiaplasty: <input type="checkbox"/> Minora <input type="checkbox"/> Majora | <input type="checkbox"/> Hysteroscopy |
| <input type="checkbox"/> Vaginoplasty | <input type="checkbox"/> Endometrial Resection |
| <input type="checkbox"/> Perineorrhapy/Perineoplasty | <input type="checkbox"/> Endometrial Ablation/HTA |
| <input type="checkbox"/> Laser Resurfacing <input type="checkbox"/> Hair Reduction | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Hymenoplasty | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> Clitoral Hood Reduction | <input type="checkbox"/> Septoplasty |
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Dilatation and Curretage |
| <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Cystoscopy with Bladder Botox |

Options of surgery were discussed such as expectant management, medical management, no surgery,

Risks of surgery were also discussed such as anesthesia, infection, bruising, bleeding, hemorrhage, transfusion, HIV, Hepatitis, anaphylaxis, aspiration, damage to internal organs such as bowel, bladder, urethra, ureter, major vessels, nerves, et al. Incisional hernias were discussed. The possibility of catheterization may be needed, an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted. The possibility that the procedure may fail or a recurrence of symptoms may occur was also discussed at length. She understands further procedures or surgeries may be needed in the future for revision/repair/removal. No guarantees are implied or given to the patient regarding the safety and efficacy of the procedure. She has had a chance to ask all her questions to her satisfaction. The option to decline or delay surgery has been discussed at length. The patient wishes to proceed with surgery.

The possibility of infection/rejection/erosion/pain due to mesh or tissue were discussed if they are used. The type of implant (if needed) was discussed fully with the patient and she has agreed to its use in repairs. She understands that pain/dysparunia may occur with and without the use of mesh or tissue.

PATIENT SIGNATURE _____

PHYSICIAN SIGNATURE _____

DATE _____

REVIEWED _____ NO CHANGES _____ DATE _____