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 p refer and encourage e-mail communication for speed and efficiency)
When is it the best time to reach you? Mon Tue Wed Thu Fri
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 patients) ____
City/State/Zip____
Social Security # ________________ Drivers License # ________________ Birthdate ____________________
Employer _____________________________________ Occupation ___________________________________
Home Phone ___________________ Work Phone ___________________ Cell 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 _____________Time __________

HIPAA Notice of Privacy Practice

How We Collect Information About You: South Coast Urogynecology and its employees and collect data through the following but not limited to the submission of the Health and Physical (H&P) registration forms, letters, phone calls, emails, and office notes either required by law, or necessary to process requests for medical care through our organization.

What We Do Not Do With Your Information: Information about your financial status and medical conditions and care that you provide to us in writing, by phone, via email (including information left on voice mails), contained in or attached to your medical chart, or directly or indirectly given to us, is held in the strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients or clients who receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient or client.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health care services which may require communication between South Coast Urogynecology providers, medical produce or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent of purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for a hit counter that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of South Coast Urogynecology. We reserve the right to use non-identifying information about our patients or clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Authorization to leave messages

I give my permission for the staff of South Coast Urogynecology to give or leave messages or information regarding medication, surgery, lab results, appointments and healthcare by the following checked options.

☐ My home telephone answering machine ______________________________

☐ My email address ______________________________

☐ My cell phone voice message ______________________________

☐ With a family member (name & contact#) ______________________________

Signature of patient or responsible party ____

Print Name ____Date _____________Time __________

03/16/2012

PAYMENT POLICY

Thank you for choosing us as your specialist. 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 some 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. The 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. **Claim 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. **Bounded 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 ____

Print Name ____Date ______________Time ___________

PAYMENT POLICY FOR AESTHETIC SURGERY

Dr. Alinsod is the leading surgeon 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 50% of the deposit will be retained for a canceled surgery that is not reschedule with Dr. Alinsod.

We accept cash, all major credit cards, and cashiers checks. 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.

I have read and understand the Payment Policy for Aesthetic Surgery and agree to abide by its guidelines.

Signature of patient or responsible party ____

Print Name ____Date ____________Time __________

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**)
Phone (Work) ______________________________ ☐Yes ___________
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 LABIAL AND/OR VAGINAL SURGERY

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

INTERESTED IN NON-SURGICAL THERMIVA

☐ To tighten the labia majora
☐ To tighten the vagina
☐ To treat a leaky bladder
☐ To reduce urinary urgency and frequency
☐ To improve vulvar and vaginal moisture
☐ To improve sensitivity of tissues
☐ To improve or achieve orgasms
☐ Reduce painful intercourse

INTERESTED IN AESTHETIC LASERS/IPL/RADIOFREQUENCY TREATMENTS

☐ I want Spot Fat Reduction/iLipo/Thermi 250
☐ I want Vulvar Lightening/Anal Bleaching
☐ I want to remove red or brown spots
☐ I want Fotofacial/Fraxel
☐ I want Hair or/and Vein reduction
☐ I want Skin Tightening
☐ I want Botox/Skin Fillers
☐ I want Stretch Marks/Scar Reduction
☐ I want Collagen/Vitamin C Facials
☐ I want info on Skin Care Products

INTERESTED IN BIO-IDENTICAL HORMONES

☐ I want information on bio-identical hormone therapy

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Circle all that apply, Give details

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active? Yes No
What type of exercise?____________________________
Do you now have or have you ever had:
Neurologic problems(seizures, headaches, weakness, paralysis) ? Yes No ______________________
Psychiatric problems? Depression? Mania? Bipolar? Yes No ______________________
Head/Ear/Eyes/Nose/Throat Problems? Yes No ______________________
Thyroid problems or glandular problems? Yes No ______________________
Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat?Yes No ______________________
Lung Problems? Asthma? Short of Breath? Yes No ______________________
Breast Problem? Mass? Lumpiness? Discharge? Pain? Yes No ______________________
Gastrointestinal (stomach) problems (gas, reflux, irritable bowel)? Yes No ______________________
Kidney or bladder disease? Stones? Infections? Blood in urine? Yes No ______________________
Liver problems such as hepatitis? Yes No ______________________
Hematologic problems such as bleeding or anemia? Yes No ______________________
Diabetes (insulin dependent/oral medication) or low sugar? Yes No ______________________
Musculoskeletal (bones, joints, muscles) problems? Yes No ______________________
Circulation problems (varicose veins, thrombosis, blood clots)? Yes No______________________
Cancer or Pre Cancerous Conditions Yes No ______________________
High Blood Pressure or Low Blood Pressure/Fainting Spells Yes No ______________________
Hernias in the abdomen? Yes No ______________________
Problems with anesthesia, nausea, anxiety reaction? Yes No______________________
STD (HIV, Gonorrhea, Chlamydia, Hepatitis, Syphilis, Warts) Yes No ______________________
OtherProblems____
____
____

PAST SURGERIES OR PROCEDURES OR HOSPITALIZATIONS
☐**NONE**
Please list with date:
____
____
____
____

FAMILY HISTORY: (Write which has occurred in any blood relative and write relationship to you):
____ None significant
____ Family ____
____

SOCIAL HISTORY:
Marital status: S M W D

Education:______________________________

Occupation: ☐Not Working ☐Working Where Working ________________________________
What Occupation ________________________________

Tobacco use: No Yes Caffeine use: No Yes
Alcohol use: No Yes Other Drugs No Yes
Abuse No Yes Describe ____

MEDICATIONS:
☐**NONE** ☐**SEE ATTACHED LIST**
Please list all current medications and dosages

____
____
____
____

EXAMINATION:
Constitutional: Ht___________ Wt__________ BMI_________

Temp________BP __________ Pulse __________ Respiration _________

	Normal	**Abnormal**
Appearance:	[ ]	[ ]
HEENT:	[ ]	[ ]
Heart:	[ ]	[ ]
Lungs:	[ ]	[ ]
Breast/Chest:	[ ]	[ ]
Abdomen:	[ ]	[ ]
Extremities:	[ ]	[ ]
Skin	[ ]	[ ]
Lymph Nodes	[ ]	[ ]
Hernias	[ ]	[ ]
Pelvic:	[ ]	[ ]

Other____
____
____
____

Drawings/Measurements:

IMPRESSION:

____
____
____
____
____
____
____

PLAN & RECOMMENDATIONS (AESTHETIC):

____Labia Minora Plasty
- ____Barbie Appearance
- ____Rim Appearance
- ____Hybrid
- ____No preference

____Labia Majora Plasty
____Clitoral Hood Reduction
____Vaginoplasty
Tightness to approximately:
- _____ "**one** finger"
- _____ "**two** fingers"
- _____ "**three** fingers"

____Perineorrhaphy / Perineoplasty
____Hemorrhoidectomy/Anal Skin Tag Removal

____Labia Minora Revision
- ____Barbie Appearance
- ____Rim Appearance
- ____Hybrid
- ____No preference

____Labia Majora Revision
____Clitoral Hood Reduction Revision
____Vaginoplasty Revision
Tightness to approximately:
- _____ "**one** finger"
- _____ "**two** fingers"
- _____ "**three** fingers"

____Perineorrhaphy / Perineoplasty Revision
____Hemorrhoidectomy/Skin Tag Revision

____Skin Resurfacing AREA: ______________________________

____Resuturing AREA: ______________________________

____Hymenoplasty

____ThermiVa

____PRP

DISCUSSIONS:
- ☐ Risks/Benefits/Options of procedure
- ☐ Meet with Finance/Business Office
- ☐ Meet with Scheduler
- ☐ Read Educational Materials
- ☐ Review Website Videos and Articles
- ☐ Review Pre and Post Op Instructions
- ☐ Discuss/Schedule Pre & Post Op Photos
- ☐ 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:

____Suburethral Sling, Cystoscopy
____Anterior Repair, Paravaginal Repair
____Posterior Compartment Repair
____Enterocele Repair
____Vaginal Vault Suspension
    ____SSLS
    ____PIVS

____Laparoscopy
____Lysis of Adhesions
____Fulguration of lesions
____Cystectomy
____LUNA
____Ureteral Dissection
____Laparotomy

____TVH, Total Vaginal Hysterectomy
____TAH, Total Abdominal Hysterectomy
____LSH, Laparoscopic Supracervical Hys.
____LAVH, Laparoscopically Assisted Vaginal Hysterectomy
____LH, Laparoscopic Hysterectomy

____Bilateral Salpingo-oophorectomy
____Unilateral Salpingo-oophorectomy
____Ovarian Cystectomy

____Labiaplasty:____Minora ____Majora
____Vaginoplasty
____Perineorrhapy/Perineoplasty
____Laser Resurfacing ____Hair Reduction
____Hymenoplasty
____Clitoral Hood Reduction
____Abdominoplasty
____Hemorrhoidectomy

____Hysteroscopy
____Endometrial Resection
____Endometrial Ablation/HTA
____Polypectomy
____Myomectomy
____Septoplasty
____Dilatation and Curretage
____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/dyspareunia may occur with and without the use of mesh or tissue.
____
____

PATIENT SIGNATURE ____

PHYSICIAN SIGNATURE ____

DATE ________________ **Time** ________________

REVIEWED______________ **NO CHANGES**__________________ **DATE** _________**TIME**_________

03/06/12