Dear Patient,

This packet contains information regarding both you and your visit. It is divided into 3 sections.

***Section I** contains an appointment card, driving directions on how to locate our office, as well as hotel information in case you are not from the Atlanta area.*

***Section II** is your **Patient Registration Information**. It is very important that you complete this section and **return it to our office ASAP**. Since it is very important that we receive this information back **prior** to your appointment, we have provided you with 3 ways for you to complete this information and return it to us.*

1. *If we have mailed this packet to you, we have enclosed a self-addressed stamped envelope for your convenience.*
2. *If you are completing this patient packet online, please make sure you hit **send** after completing ALL sections. It is also suggested that you print out a copy for your records and bring to your appointment.*
3. *If you are able to print out this packet from home, please fax or mail the requested documentation to the address / fax number listed below.*

***Section III** is important for you to keep for your reference. It contains information regarding women's health and our doctors, both Dr. John R. Miklos and Dr. Robert D. Moore.*

We are looking forward to meeting you!!!!!!

Sincerely,

John R. Miklos, MD
Robert D. Moore, DO

Atlanta Urogynecology Associates
Atlanta Center for Aesthetic Vaginal Surgery

Directions

Dr. Miklos and Dr. Moore's practice is located in Alpharetta, about 25 minutes from the Perimeter and 40 minutes from Buckhead.

From the South:
Take 1-85 North, and take the exit for Highway 400. Go through the tollbooth and continue on 400 North. Take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the North:
Take Highway 400 South, and take Old Milton Parkway (exit #10). Turn left onto Old Milton Parkway. Turn left at the fourth traffic light onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the East:
Take I-285 West, and take the exit for 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the West:
Take I-285 East, and take the exit for 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

3400 Old Milton Parkway Bldg. C ~ Suite 330, Alpharetta, GA 30005
Phone: 770-475-4499 Fax: 770-475-0875
www.miklosandmoore.com www.lvratlanta.com

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Atlanta Center for Aesthetic Vaginal Surgery

Patient Registration Information

Patient Personal Information

Name: (Last, First, Middle Initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Social Security # _____

DOB: _____ Age: _____ Marital Status: Single Married Divorced Widowed

Spouses Name: _____ Spouse Social Security # _____

Emergency Contact _____ ***Phone*** _____

Patient Responsible Party Information

Responsible Party: _____ DOB: _____

Relationship to Patient: SELF SPOUSE OTHER _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Employer: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient Insurance Information

Name of Insured: _____ Relationship to Insured: _____

DOB: _____ Insurance Company: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

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Atlanta Urogynecology Associates
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FINANCIAL PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is our Financial Policy. Please read carefully, prior to any treatment with our physicians.

Attached is a list of commonly used health insurance coverage terms. Please refer to this list, as needed, for clarification of the information in this policy.

- *Deductibles and co-insurances are due at the time services are rendered.*
- *Patients without medical insurance will pay for services in full, at the time of service. (Payment methods accepted: Cash, Money Orders, Cashiers Checks, Visa, MasterCard, Amex, Discover) Please note: No personal checks over $3500*
- *Surgery Payments (Medicare Excluded): A **$1,000** (in-state patients) / **$1,500** (out-of-state patients) deposit is required to schedule surgery. **This is non-refundable, should you choose to cancel.***
- *You will receive an **estimate** of any deductibles. co-payments or coinsurances on your pre-operative visit. Payment is due at this time (the $1,000 or $1,500 deposit will be deducted from this estimate).*

We must emphasize that as physicians our relationship is with you, not your insurance company. We file insurance claims as a courtesy to our patients, but all charges are your responsibility. Not all of the services we provide are covered by your insurance provider. This is NOT decided by you, but rather your insurance company. It is important that you read and understand YOUR insurance policy and its requirements for coverage.

Private insurance is a contract between you and your insurance provider. We will NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, usual and customary payments, etc; other than to supply factual information regarding the services rendered, as necessary.

Any questions you may have regarding laboratory billing, hospital billings, including the anesthesiologist are to be directed to the hospital. A payment to this office is for the Physician ONLY.

Signature: _____ Date: _____

SHOULD YOU HAVE ANY QUESTIONS REGARDING THE CONTENT OF THIS FORM, PLEASE SEE A MEMBER OF OUR FRONT OFFICE STAFF FOR CLARIFICATION, PRIOR TO SIGNING!

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Commitment Guidelines

We understand that with life's uncertainties you may need to cancel your appointment with us. If so, please give our staff a minimum of **48-business *hour notice***.

All NEW PATIENTS –If you do not keep a scheduled appointment (no show) or have not cancelled with at least a **48 *business hour notice***, *a $**250.00** fee will be charged to your credit card.*

*ALL ESTABLISHED PATIENTS -If you do not keep a scheduled follow up appointment (no show) or cancel, and do **NOT** give at least a 48 business hour notice, a **S150.00** fee will be charged to your credit card. Repeated, missed or cancelled appointments may result in termination of services with Atlanta Urogynecology Associates.*

Please be advised that the staff of Atlanta Urogynecology Associates reserves the right to reschedule patients who arrive more than 10 minutes late for their scheduled appointment time.

_____ _____

Signature Date

SHOULD YOU HAVE ANY QUESTIONS REGARDING THE CONTENT OF THIS FORM, PLEASE SEE A MEMBER OF OUR FRONT OFFICE STAFF FOR CLARIFICATION, PRIOR TO SIGNINGH

Physician Payment Authorization

Patient Name: _____

Primary Insurance Policy Holder: _____

Primary Holder Date of Birth: _____

Insurance ID#: _____ Group #: _____

I hereby authorize my above named insurance provide to mail payment directly to said physician at Atlanta Urogynecology Associates, on my behalf. These payments should be made payable and mailed to:

Urogynecology, PC
3400 Old Milton Parkway
Building C, Suite 330
Alpharetta, GA 30005

Should my insurance company send payment directly to me, the patient, I will endorse and forward all payments to Atlanta Urogynecology Associates, for the services rendered. All checks will be forwarded to the address above.

I authorize Atlanta Urogynecology Associates to release any information pertinent to the resolution of claims and receiving payment to all my insurance carriers or attorney working on my behalf.

A photocopy of this assignment shall be considered as valid and effective as the original.

_____ _____
Signature Date

Should you have <u>ANY</u> questions regarding the content of this form, please see a member of our front office staff for clarification, <u>PRIOR TO SIGNING</u>!!

COMMON HEALTH INSURANCE COVERAGE TERMS

DEDUCTIBLE: *The deductible refers to the amount* of *money that the patient will need to pay before any payments are made from the insurance company. This is usually* a *yearly amount and will start over, the following year. Some office visit services may be available without meeting the deductible first. This is determined by your insurance company.*

CO-INSURANCE: *This is the amount that would be paid by the patient before the insurance pays. This is in addition to the deductible. Some insurance plans will allow the patient use some services with just the co-insurance payment. Like visiting the doctor, even before the deductible is met. This is determined by your insurance company.*

CO-PAYS: *This is another term used for, or in place* of *"co-insurance". Co-Pays are generally collected for office visit services as* a *flat dollar amount. Coinsurances are generally* a *percentage* of *the total amount due for services.*

LIFETIME MAXIMUM: *This is the maximum amount* of *money the health insurance policy will pay for the entire life. Pay attention to individual lifetime maximums and family lifetime maximums, as they can be different.*

EXCLUSIONS: *The exclusions (non-covered services} are the procedures and examinations that your policy does NOT cover. You will be responsible for these charges.*

PRE-EXISTING CONDITIONS: *This could be* a *disease or illness that the patient had prior to obtaining the insurance policy. Depending on your plan, preexisting conditions may not be covered at all, after* a *certain time frame, or will be covered. This is determined by your insurance company.*

WAITING PERIOD: *This is the time that the patient will have to wait until certain health services are payable by the insurance company. This time frame is determined by your insurance company.*

COORDINATION OF BENEFITS: *If the patient has two* or *more insurance carriers that will cover services, the insurance companies will NOT pay double benefits. In this case, the insurance companies will coordinate benefits to make sure each pays* a *portion* of *the service fees. This is determined by the insurance companies involved.*

GRACE PERIOD: *This is the amount* of *time one ha$ to pay their health insurance premium after the original due date* & *before coverage is cancelled:*

Atlanta Urogynecology Associates

Atlanta Center for Aesthetic Vaginal Surgery

INSURANCE PAYMENT/FORWARD AGREEMENT

(BLUE CROSS/BLUE SHIELD ONLY)

Atlanta Urogynecology Associates is an Out-of-Network provider with patient's who have Blue Cross Blue Shield as their insurance carrier. Because of this, it is standard protocol for Blue Cross Blue Shield to send payments to the patient, for the services that are rendered by an Out-of-Network provider.

As the patient, and the insured by Blue Cross Blue Shield, it is your responsibility to forward all checks and associated paperwork (known as Explanation of Benefits) to our office. This information must be received in our office within 15 days of your receipt from Blue Cross Blue Shield. Failure to comply will result in our office charging your credit card for full amount of payment received by Blue Cross Blue Shield.

I _____, acknowledge the above statement and do understand that I am responsible for making sure all payments paid to me, for services rendered at Atlanta Urogynecology Associates is forwarded to them, upon receipt, or I will be charged in full for such payments, not sent immediately.

_____ _____

Patient Signature Date

Card Type: (Check One) VISA AMEX MASTERCARD

Card Number: _____

Expiration Date: _____

Cardholder Name: _____

Billing Zip Code: _____

Authorizing Signature: _____

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Medical History

Please complete the following information before your first visit

Date of Visit: _____/_____/_____

Name: _____, _____ _____ **Date of Birth:** _____/_____/_____
(Last) (First) (MI)

Chief Complaint **(What problem(s) brings you to our office?)**

_____

_____

_____

_____

Past Medical History: **Please circle Y or N**

Y / N Asthma	**Y / N Pneumonia**	**Y / N Ulcers**	**Y / N Tuberculosis**
Y / N Lung Disease	**Y / N Depression/Anxiety**	**Y / N Kidney Infection**	**Y / N Lupus**
Y / N Seizures / Convulsion	**Y / N Venereal Disease**	**Y / N Kidney Stones**	**Y / N Arthritis**
Y / N Heart Disease	**Y / N High Blood Pressure**	**Y / N Arrhythmia**	**Y / N Migraines**
Y / N Stroke	**Y / N Fibromyalgia**		

Y / N Cancer – If yes, what type? _____

Y / N Stomach Problems – type? _____

Y / N Glaucoma – type? _____

Y / N Thyroid Disease – type? _____

Y / N Diabetes – type? _____

Y / N Hepatitis – type? _____

Past Surgical History **(List ALL surgeries with the date, if possible)**

Previous incontinence / bladder surgeries: _____ NO _____YES Type: _____

Other surgeries (Include any abdominal or plastic surgery)

_____

_____

_____

_____

_____

_____

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Medical History – Page 2

Name: _____, _____ _____
(Last) (First) (MI)

Allergies **(Please list any allergies along with the type of reaction you experienced):**

_____

_____

Medications **(Please list all medications you currently take, including dosage and how often you take it. also include over-the-counter medications & herbal supplements):**

_____

_____

_____

_____

Social History

Occupation: _____ Race: _____ Religion: _____

Marital Status: _____ Married _____Single _____Divorced _____Widow _____ Separated

Spouse Name: _____ Spouse Occupation: _____

Regular Exercise: _____ Yes _____ No How Often? _____

Are you sexually active? _____ Yes _____ No How Often? _____
(This will help us choose the types of treatments more suitable for your lifestyle)

Cigarettes: Have you ever smoked Cigarettes? _____ Yes _____ No How many years? _____

Packs per day? _____ Are you currently smoking? _____ Yes _____ No

Caffeine: Coffee – cups per day _____ Caffeinated drinks (tea /soda) – cups per day _____

Alcohol: _____ Yes _____ No How often? _____ What is consumed? _____

Illegal Drugs: _____ Yes _____ No How often? _____ Which Drugs? _____

Family History (Check any conditions in your family & write in their relationship to you)

Condition	Relationship
_____ Heart Disease	_____
_____ High Blood Pressure	_____
_____ Stroke	_____
_____ Breast Cancer	_____
_____ GYN Cancer (Ovarian)	_____
_____ Colon Cancer	_____

GYN History

Last PAP Smear _____ Normal? _____
Last Mammogram _____ Normal? _____
Last GYN Exam _____/_____/_____
Last Menstrual Period _____/_____/_____
Problems with period? _____
Date of Menopause _____/_____/_____
# of Pregnancies _____ # of Deliveries _____
# of Vaginal Deliveries _____
# of C-Sections _____

Medical History – Page 3

Name: _____, _____ _____
(Last) (First) (MI)

Review of Symptoms **(Check any conditions present today)**

Constitutional

_____ Fever
_____ Chills
_____ Weight Loss

Gastrointestinal

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Blood in Stool
_____ Difficulty Swallowing

Psychiatric

_____ Depression
_____ Nervousness
_____ Anxiety
_____ Mood Swings

Respiratory

_____ Cough
_____ Shortness of Breath

Neurological

_____ Headache
_____ Blurred Vision
_____ Numbness
_____ Tingling
_____ Dizziness

Endocrine / Metabolic

_____ Hot Flashes
_____ Night Sweats
_____ Excessive Thirst
_____ Excessive Hunger
_____ Excessive Urine Output

Cardiovascular

_____ Heart Fluttering
_____ Chest Pain

Skin

_____ Bruise Easily
_____ Rash
_____ Change in Mole
_____ Non-healing Sore

Blood / Lymph

_____ Swollen Glands
_____ Bleeding Problems

Genital / Urinary

_____ Painful Urination
_____ Blood in Urine

_____ **I have none of these problems today**

Please fax, email or mail a completed copy of this paperwork to our office before your scheduled appointment.

DO NOT MAIL ORIGINALS

Keep the original paperwork and bring it with you to your appointment.

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QUALITY OF LIFE QUESTIONNAIRE

Name: _____ **Date of Exam:** _____/_____/_____

Has urine leakage and or prolapse affected your:	None	Slightly	Moderately	Greatly
Ability to do household chores?	_____	_____	_____	_____
Physical recreation such as walking, swimming or exercise?	_____	_____	_____	_____
Entertainment activities (movies, concerts, etc)?	_____	_____	_____	_____
Ability to travel by car or bus more than 30 minutes?	_____	_____	_____	_____
Participate in social activities outside the home?	_____	_____	_____	_____
Emotional health (nervousness, depression, etc)?	_____	_____	_____	_____
Feeling frustrated?	_____	_____	_____	_____

Do you experience, and, if so how much are you bothered by:				
Frequent urination?	_____	_____	_____	_____
Urine leakage related to feeling of urgency?	_____	_____	_____	_____
Urine leakage related to physical activity, coughing, or sneezing?	_____	_____	_____	_____
Small amounts of urine leakage (drops)?	_____	_____	_____	_____
Difficulty in emptying your bladder?	_____	_____	_____	_____
Pain or discomfort in the lower abdomen or Genital area?	_____	_____	_____	_____

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Labiaplasty Questionnaire

(Medical Illustration Attached)

1) Are you here for labia reduction surgery ? Yes ☐ No ☐

2) Does your labia minora protrude past the labia majora? (see medical illustration) Yes ☐ No ☐

3) What color are your labia minora skin edges? pink ☐ dark ☐

4) Have your labia minora skin edges changed in color over time ? Yes ☐ No ☐

5) At what point did your skin edge color change from pink to dark ?
Adolescence ☐ Pregnancy ☐ Other _____

6) Have you always had enlarged labia minora? Yes ☐ No ☐

7) If "No" to question #6 then when did the enlargement occur?
Adolescence ☐ Pregnancy ☐ Other_____

8) If you decide on labia minora reduction (labiaplasty), would you prefer that your labia reduced so that the edge :

a) Still protrudes past the labia majora ☐

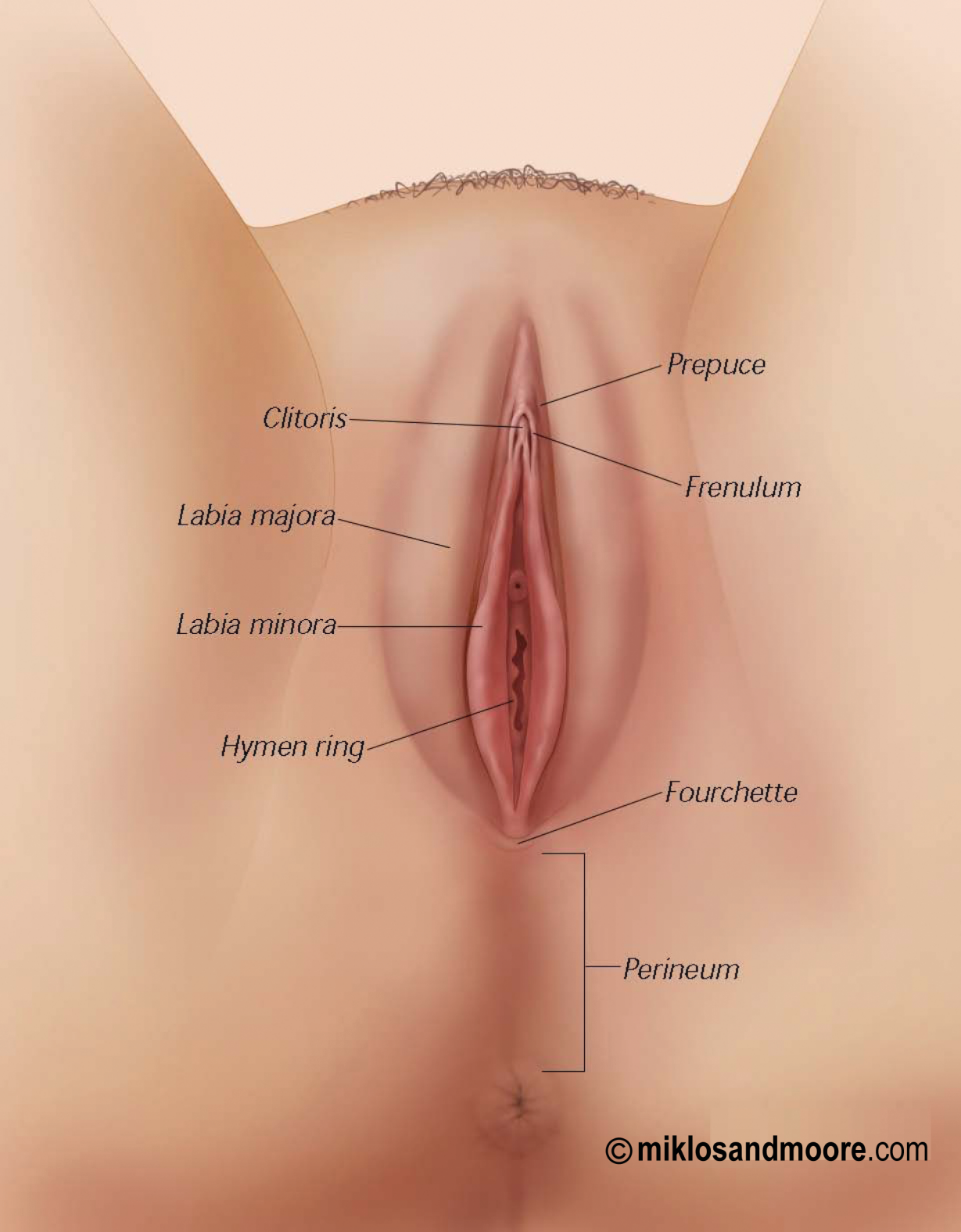
b) To the level of the labia majora ☐

c) Below the level of the labia majora ☐

9) If you decide on labia minora reduction (labiaplasty), would your prefer that your labia skin edges are : Pink ☐ Dark ☐

Patient Name_____ Date of Birth_____

Date of Exam _____



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LABIAPLASTY PAIN DIARY

I am a 38-year-old stay-at-home mom with 2 young children. I had trepidations about the upcoming surgery (labia reduction & removal of excess prepuce) because I did not want to have to take pain meds post surgery and was worried if I would be able to care for my children while recuperating from surgery. Dr. Miklos and Dr. Moore told me that most people are up and about the next day after surgery and felt fine with just a little discomfort. As you can see from my pain journal below, I was pain free after the surgery with no need to take any pain medications.

Surgery day:
1 hour before surgery I was given a "margarita concoction" by the nurse, which made me feel very relaxed. All I remember is being put on the operating table, and the nurse putting a mask over my mouth. She told me to take deep breaths & I was asleep.

Recovery room:
I opened my eyes in the recovery room. The nurse assessed my pain level. Between 1-10, 1 being no pain and 10 the most pain, I was a 1. I did not feel any pain. Within the hour I still felt fine but was a bit nauseous. The nurse gave me some Phenergan through my IV and the nausea went away. I was given some ice chips to see if I could hold the ice chips down. I was then asked if I was able to urinate in the bathroom. I was helped to the bathroom and urinated with no problem or pain. The nurse decided that I was good to go home and I was discharged.

I stayed at a friend's home the first night after surgery. I had no pain when I arrived at my friend's home. I walked upstairs and got into bed. I went to the bathroom on my own and was asleep by 10pm. I did not take any pain meds because I was not in any pain.

1 day after surgery:
I got up on my own, went to the bathroom and drove myself 10 miles to my home to relieve my babysitter. I had no pain while driving but was a little "out of it" - I felt fine. I got my girls ready for school and drove them to school at 8am. I did a few errands in the morning. At noon I started my antibiotics (Levaquin) total of 5---1 each day). I also took the 1 tablet to prevent yeast infection (Diflucan). At the nurse's request to help the swelling go down, I took 1 anti-inflammatory/pain tablet (Toradol). Since Toradol made my stomach upset, I took the anti-nausea pill (Phenergan 25mg) which made me feel better. I decided not to take anymore Toradol after the nausea side effect.

The only discomfort I felt on the day after surgery until 9 days post surgery was having to be very careful when I sat down (I could not put any pressure on my vagina because it was very sensitive and swollen). To solve this problem, I curved my back when I drove the car or sat in a chair. Loose sweatpants (and no undies) are a must for the next week.

8 days after surgery:
I experienced external itching (more severe at night) from the dissolving sutures. I still needed to sit on my bum because it was very sensitive down there. Discomfort was decreasing everyday. I still wore loose sweatpants with no undies because the sutures would stick to my underwear.

10 days after surgery:
I can sit down normal and not curve my back. The itching is still there but not as severe.

Summary: This surgery was a pain free experience. No pain meds were needed and I was able to do day-to-day activities the following morning. Just remember to have a weeks worth of nice loose fitting cozy sweatpants and expect some itching up to 10 days after surgery.

-K.G., 38 years old- recently televised with Dr. Miklos and Dr. Moore performing her surgery.
(Results may vary per patient)

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AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____

Name & Address of Physician Sending Records:

_____

_____

_____

_____

The above named physician(s) are hereby authorized to release to:
John R. Miklos, MD ***Robert D. Moore, DO*** ***Gretchen K. Mitchell, MD***

I, _____, *hereby authorize the above named facility/physician to release my medical records, including any psychiatric, alcohol or drug abuse information. Specifically, the following:*

___ Laboratory Reports
___ Progress Reports
___ History / Physical
___ Radiology Reports
___ Discharge Summary
___ Pathology Reports
___ Psychiatric Notes
___ Operative Reports
___ Special Diagnostic Reports (EKG, EEG, etc)
___ Other: _____

The information is needed for the following purpose (check all that apply):

___ Continued care by the receiving facility/physician
___ Claims settlement with insurance company
___ Needed to receive aid by the above named agency
___ Legal proceedings or advise
___ Personal Use
___ Other: _____

SIGNATURE: ***(This authorization is valid for a period of 90 days from the date signed)***
I have read and understand this Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

_____ _____
Signature Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____

I hereby authorize Atlanta Urogynecology Associates to release information to any medical facility or physician to which I may be referred by this office. I authorize Atlanta Urogynecology Associates to obtain copies of medical information from any medical facility or physician, which may be related to my care and or treatment. I also authorize Atlanta Urogynecology Associates to release medical records from this office, related to my medical history, physical examination, or surgery to other physicians who care for me to provide continuity of care and communication between my physicians on my behalf.

I hereby release this office and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may arise as a result of the release of information authorized by this Consent Form.

I have read and understand this Consent for Release of Medical information and have voluntarily and knowingly signed such consent.

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature

LIST OF PHYSICIANS WHO CARE FOR YOU:

Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number

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