

Atlanta Urogynecology Associates
Atlanta Center for Aesthetic Vaginal Surgery

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*

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

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 I-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:

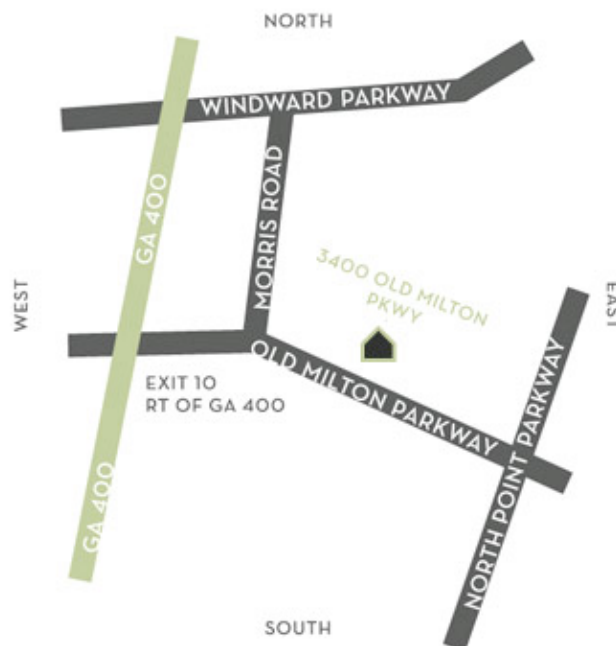
Take Highway 400 South, and take Old Milton Parkway (exit #10). Turn left onto Old Milton Parkway. Turn left at the fourth traffic light onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead,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



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Traveling to Atlanta

Dr. Miklos and Dr. Moore are world-renowned surgeons and patients travel globally to Atlanta to seek their surgical expertise. Whether you are driving to Atlanta or traveling internationally, it is easy to make arrangements to have your surgery performed by Dr. Miklos and Dr. Moore. Our staff is dedicated to our patients and will assist you in your travel plans.

Hotel Locations located close to Northside Hospital

Our patients prefer the Hilton Suites Atlanta Perimeter as opposed to other hotels:

Hilton Suites Atlanta Perimeter

6120 Peachtree Dunwoody Rd, Atlanta, GA
770.658.0808

- Close proximity to the hospital
- Free shuttle service
- Spacious rooms ~ open floorplan which includes a separate sitting area
- All rooms are equipped with a refrigerator and microwave

Other options close to Northside Hospital

Comfort Suites

6110 Dunwoody Rd, Atlanta, GA 30329
770.828.0330

Hyatt Place Atlanta Perimeter

1005 Crestline Pkwy, Atlanta, GA 30328
770.730.9300

The Westin Buckhead Atlanta

3391 Peachtree Rd, N.E., Atlanta, GA 30326
404.365.0065

Located near Atlanta Urogynecology Associates:

Embassy Suites Alpharetta

5955 North Point Pkwy
Alpharetta, GA
678-566-8800

Hilton Garden Inn Atlanta Woodward

4025 Windward Plaza
Alpharetta, GA
770-360-7768

Hampton Inn North Point

10740 Westside Pkwy
Alpharetta, GA
770-640-5511

Staybridge Suites

3980 North Point Pkwy
Alpharetta, GA
770-569-7200 or 800-239-8000

Atlanta Marriott Alpharetta

5750 Windward Pkwy
Alpharetta, GA
770-754-9600

Additional Services we can assist you with:

Transportation

Arrangements must be made for someone to take you home or to the hotel (if from out of town) from surgery. You will not be allowed to drive yourself or take any form of public transportation (cab, bus, etc.).

Nursing Care

If you are alone, you have the option to hire a nurse to come to the hospital, sign you out, transport you to the hotel, and make sure you are set up and comfortable for the night.

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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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Medical History

Please complete the following information before your first visit

Date of Visit: ____/____/____

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

Date of Birth: ____/____/____

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? _____

<p><i>Family History</i> (Check any conditions in your family & write in their relationship to you)</p> <table style="width: 100%;"><thead><tr><th style="text-align: left;"><u>Condition</u></th><th style="text-align: left;"><u>Relationship</u></th></tr></thead><tbody><tr><td>_____ Heart Disease</td><td>_____</td></tr><tr><td>_____ High Blood Pressure</td><td>_____</td></tr><tr><td>_____ Stroke</td><td>_____</td></tr><tr><td>_____ Breast Cancer</td><td>_____</td></tr><tr><td>_____ GYN Cancer (Ovarian)</td><td>_____</td></tr><tr><td>_____ Colon Cancer</td><td>_____</td></tr></tbody></table>	<u>Condition</u>	<u>Relationship</u>	_____ Heart Disease	_____	_____ High Blood Pressure	_____	_____ Stroke	_____	_____ Breast Cancer	_____	_____ GYN Cancer (Ovarian)	_____	_____ Colon Cancer	_____	<p><i>GYN History</i></p> <p>Last PAP Smear _____ Normal? _____</p> <p>Last Mammogram _____ Normal? _____</p> <p>Last GYN Exam _____ / _____ / _____</p> <p>Last Menstrual Period _____ / _____ / _____</p> <p>Problems with period? _____</p> <p>Date of Menopause _____ / _____ / _____</p> <p># of Pregnancies _____ # of Deliveries _____</p> <p># of Vaginal Deliveries _____</p> <p># of C-Sections _____</p>
<u>Condition</u>	<u>Relationship</u>														
_____ Heart Disease	_____														
_____ High Blood Pressure	_____														
_____ Stroke	_____														
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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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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 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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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 **\$150.00** 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

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Atlanta Urogynecology Associates
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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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Atlanta Urogynecology Associates
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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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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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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 has to pay their health insurance premium after the original due date & before coverage is cancelled:*

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~ Patient Information ~

Can you please take some time to help us with our marketing approach? We currently advertise in numerous media outlets and would like to know how you found out about us.

Patient Name _____ **Date** _____

Please check any of the following that apply?

Referral - Physician _____

Friend _____

If referred by a friend, may we thank them? Y / N

Magazine -

Delta Sky

Our Websites -

Miklosandmoore.com

LVRatlanta.com

Fistularepair.com

Meshsurgeons.com

Mmedicalspa.com

Vaginalsurgeonsblog.com

Hysteropexy.com

Botchedlabia.com

Neovaginasurgeons.com

Other Websites -

Locate-A-Doc

American Health and Beauty

Labiaplastysurgeon.com

Lasertreatments.com

Labiaplasty.net

Calladoctor.net

Onlinesurgery.com

Healthnews.org

Thank you for your time, your business, and referrals.

Atlanta Urogynecology Associates
Atlanta Center for Aesthetic Vaginal Surgery

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:

I 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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