Laser Vaginal Rejuvenation Institute of Atlanta

John R. Miklos, MD, FACOG

Robert D. Moore, DO, FACOG

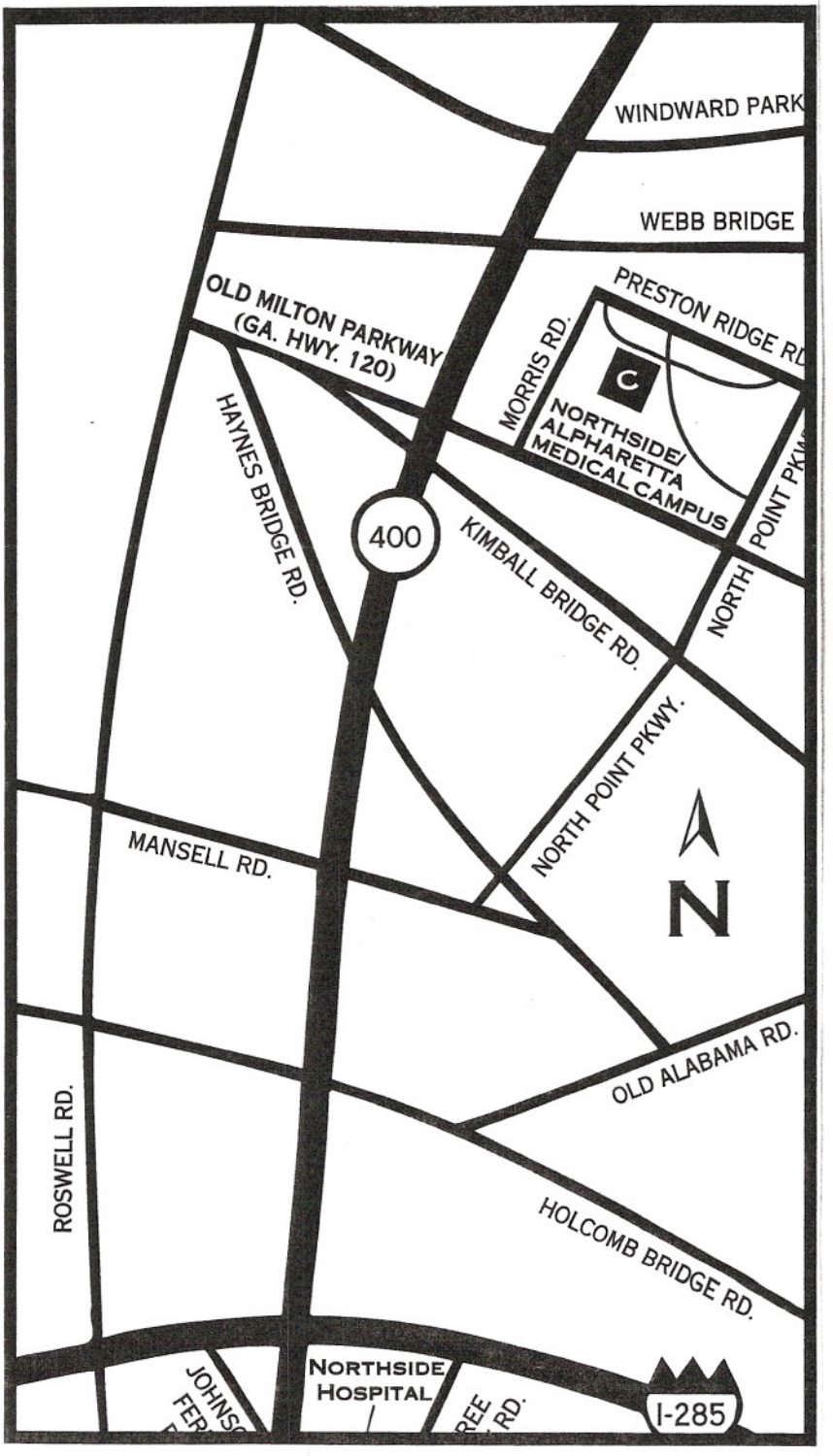
Thank you for calling our office for information on our services. Attached you will find information on Dr. Miklos and Dr. Moore, our office guidelines, payment policies and financing options. Please read carefully.

If you have scheduled an appointment, please complete all forms and return to our office as soon as possible. It is imperative that we receive any and all information requested so that your visit will be a productive one. This includes all financing approvals.

We look forward to meeting you!!

NORTHSIDE/ALPHARETTA
MEDICAL CAMPUS

3400-C OLD MILTON PARKWAY, ALPHARETTA, GEORGIA 30005 (770) 667-4000



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 exit #10 (Old Milton Parkway). 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 Highway 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 Highway 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.

Hotel – Ritz-Carlton, Buckhead

(Only 5 miles from Northside Hospital – 25 min from Jackson-Hartsfield Airport)

A familiar landmark on Atlanta's social scene, The Ritz-Carlton, Buckhead is ideally located in the heart of the city's shopping, dining, entertainment and financial district. This legendary Atlanta hotel is home to The Dining Room, the Southeast's most highly recognized restaurant for fine dining and recipient of the *Mobil Travel* Guide 2005 Five Star Award.

The Ritz-Carlton, Buckhead
3434 Peachtree Road, N.E.
Atlanta, GA 30326
Phone: 404-237-2700
Fax: 404-239-0078

The Ritz-Carlton, Buckhead will give patients of Alanta Urgynecology Corporate Rates – just mention that you are a patient of our facility, and you will be given the special rate!

- 25 minutes from Atlanta Hartsfield International Airport
- Adjacent to the Southeast's most prestigious shopping malls, Lenox Square & Phipps Plaza
- Situated in the heart of fashionable uptown Atlanta, minutes from dining & historical sites
- Gracious guestrooms & suites in the heart of Buckhead
- Home of the Dining Room, Georgia's most highly recognized restaurant
- Indoor pool, sundeck, and fitness center

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)

Laser Vaginal Rejuvenation Institute

PATIENT REGISTRATION INFORMATION

Patient Personal Information Marital Status: Single Married Divorced Widowed

Name: (Last, First, Middle Initial)_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone:_____

Email: _____ Allergies: _____

DOB: _____ Age: _____ Social Security #: _____

Spouse's Name: _____ Spouse Social Security #:_____

Patient Responsible Party Information Responsible Party: _____ DOB: _____

Relationship to Patient: SELF SPOUSE OTHER _____ SSN#:_____

Responsible Party Home Phone: _____ Work Phone: _____

Address_____City:_____State:_____Zip_____

Employer Name: _____ Phone #:_____

Address: _____City: _____ State: _____ Zip_____

Spouse Employer: _____ Phone #:_____

Address: _____ City: _____ State: _____Zip_____

Patient's Insurance Information Name of Insured: _____ DOB: _____

Primary Insurance Company: _____ Relationship to insured:_____

Primary Insurance ID Number: _____ Group # _____

Insurance Billing Address: _____ City: _____State _____ Zip _____

Secondary Insurance Company: _____ Relationship to insured:_____

Secondary Insurance ID Number: _____ Group # _____

Insurance Billing Address: _____ City: _____ State _____ Zip _____

Patient Referral Information

Referred By: _____ If referred by friend, may we thank them? Y / N

Emergency Contact Name: _____ Phone: _____ Relationship _____

Are you interested in hearing about the current clinical trials in which we are participating? Y / N

Laser Vaginal Rejuvenation Institute

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 ***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 48 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.*

WE DO NOT ACCEPT PERSONAL CHECKS!!! ONLY CERTIFIED CHECKS FROM YOUR BANK ARE ACCEPTED AS PAYMENT, IN OUR OFFICE.

_____ _____

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>

Laser Vaginal Rejuvenation Institute

PHYSICIAN PAYMENT AUTHORIZATION

PATIENT NAME: _____

PRIMARY INSURANCE POLICY HOLDER: _____

PRIMARY HOLDER DATE OF BIRTH: _____

INSURANCE ID #: _____ **GROUP #:** _____

I hereby authorize my above named insurance provider to mail payments 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 Pkwy
Bldg. 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>

Laser Vaginal Rejuvenation Institute

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, Checks, Visa, MasterCard)*
- *Surgery Payments (Medicare Excluded): A **$1,000** (in-state patient)/**$1,500** (out-of-state patient) 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 co-insurances 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 the services we provide are covered by your insurance provider. This is NOT decided by us, 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

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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. Co-insurances 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, pre-existing 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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Laser Vaginal Rejuvenation Institute

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

The information is needed for the following purpose (must be checked):

___ 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

3400 Old Milton Pkwy, Bldg. C – Suite 330, Alpharetta, GA 30005
Phone: 770-475-4499 ***Fax: 770-475-0875***
www.tvtsling.com ***www.lvratlanta.com***

Laser Vaginal Rejuvenation Institute

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 Date

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

3400 Old Milton Pkwy, Bldg. C – Suite 330, Alpharetta, GA 30005

Phone: 770-475-4499 Fax: 770-475-0875

www.tvtsling.com www.lvratlanta.com

Laser Vaginal Rejuvenation Institute

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

Y/N Cancer—If yes, what type? _____
Y/N Stomach Problems—Type? _____
Y/N Glaucoma—Type? _____
Y/N Diabetes—Type? _____
Y/N Hepatitis—Type? _____
Y/N Thyroid Disease—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? _____

_____

_____

_____

_____

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

_____

_____

Medications (Please list all medications you currently take (including dosage, 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? _____

Cigarettes: Have you ever smoked? Y/N ____ packs per day How many years? _____
Are you currently smoking? _____ Yes _____ No

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

Are you sexually active? ____ Yes ____ No If yes, how often? _____ (This will help us choose the types of treatments more suitable for your lifestyle)

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

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

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 _____

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

Atlanta UroGynecology Associates
3400 Old Milton Pkwy
Bldg. C—Suite 330
Alpharetta, GA 30005
Phone: 770-475-4499 Fax: 770-475-0875

Quality of Life Questionnaire

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?	____	____	____	____

Name: _____

Date of Exam: _____

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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