FEMALE HEALTH ASSOCIATES OF NORTH TEXAS
Jeff Hantes, D.O.
Director, Urogynecology
Texas Health Harris Methodist

CO2 Laser Skin Resurfacing

Enclosed with this packet are the pre and post care instructions for the CO2 laser skin treatment. I will need to call in 3 – 4 prescriptions to your pharmacy prior to your appointment. You will need to bring all of your prescriptions with you on the day of your procedure. It is recommended that you have someone to drive you home afterwards. There is also a numbing cream that you will need to purchase. I can call it in to the pharmacy (located in Plano) or you can purchase it at the office for $30.00 the day of your appointment. For the post treatment skin care, you have the option of purchasing Neova Skin Care from the office for $39.95 or you can purchase an over the counter balm such as Z-calm or Aquafor Ointment. Please complete the new patient paperwork and mail or fax it to the office. If you have any questions, please don't hesitate to call the office at 817-731-3936.

Informed Consent for Fractional CO2 Laser Procedures

INITIALS

____I understand that Micro-Spot Fractional CO2 laser is intended skin rejuvenation and that results may vary depending on the condition of skin, skin type, and area treated.

____ I understand that more than one treatment may be needed for optimal results.

____I certify that I have none of the known conditions that could make treatment contraindicated:

- Pregnancy or currently breast feeding
- Herpes Simplex (cold sores or fever blisters) in area to be treated
- History of keloid scarring
- Use of medications that increase photosensitivity
- Tattoo in treated area
- Auto-Immune Disorders
- Diabetes
- Using Accutane
- Use of aspirin, Ibuprofen, or other anti-inflammatory medications
- UV light exposure 3 days prior and 3 days post treatment

____I am fully aware of the possible complications from the Micro-Spot Fractional CO2 laser, including but not limited to:

- Mild to moderate discomfort
- Redness or swelling at the treated area
- Sun sensitivity
- Skin sensitivity
- Blistering
- Bruising/Swelling/Infection (rare)
- Temporary or Permanent skin pigmentation changes (rare): hypo- or hyperpigmentation
- Scarring (rare)
- Eye Exposure: Protective eyewear will be provided to me

____I understand that there are other alternative treatments for skin rejuvenation besides the Micro-Spot Fractional CO2 laser.

____I understand that photos may be taken for my medical records

____I certify that I am a competent adult of at least 18 years of age and that this consent is given freely and voluntarily.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above information and that I have had sufficient opportunity for discussion to have any questions answered.

Signature of Patient/Guardian	Print Name/Relationship	Date
Signature of Witness	Print Name/Relationship	Date

PATIENT INFORMATION AND INSTRUCTIONS
Laser Resurfacing using Mixto SX Fractional CO2 Laser

WOUND CARE

1. You will experience a burning sensation on the skin that will last between 30 minutes and 3 hours on up to the first day.

2. If you have discomfort following the treatment, take Tylenol or ask for a pain –killer prescribed by the doctor (i.e. Vicodin or Lortab). Take with food.

3. Treatment to the Facial Area will result in an appearance similar to a darker tan/ sunburn for the first day. A fine scab will be formed by the skin do not be concerned, this promotes the healing process.

4. Redness may persist up to 2 days. At this point, makeup can be applied. 3-4- Days your face will get darker, and then near the 5th day peel. More intense treatments can take up to 7 days for recovery.

5. Wash using a mild soap purpose like Neutrogena or a soap-free cleanser like Cetaphil. If you purchased the BIO2 Cosmeceuticals Post Laser Treatment, use the 'Azulene Cleanser' 4 – 6 times per day .

6. After washing your face, immediately apply the Oxymist Spray (if you purchased it) and then apply the 'Protective Recovery Balm' as needed for moisture. If you did not purchase the Bio2 Cosmeceuticals Post Laser Treatment balm, you may use a similar product such as Z-Calm or Aquaphor Ointment instead. Avoid Hot Water.

7. Eye Area: Treatment to the upper Eye Lids may result in swelling and create a slight squint. Redness may persist up to 3 days. Cleanse your eyes with cool water and dab or pat lightly with towel. Avoid Hot Water. Lubricating eye drops (i.e. artificial tears) will help to decrease dryness of your eyes.

8. If the skin around the mouth is tight, minimize facial expressions.

9. Rest. Avoid strenuous exercise, bending, straining, stooping or lifting heavy objects for 3 days after procedure. These activities may cause swelling and pain on your face and slow down your recovery.

10. Sleep with your face elevated above your heart for the first day after the procedure.

11. Avoid sun exposure for at least six months. A sunblock SPF 30 or higher should be applied every day. Use hat and sunglasses. Your skin is extremely vulnerable to the sun after having laser treatment. Protecting your skin and limiting sun exposure ensures the best cosmetic results.

12. At the time of scheduling the laser procedure, please schedule your follow-up appointment for 1 week after the procedure.

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

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Healing starts with the migration of epidermal keratinocytes from islands of undamaged tissue and from nearby epidermal adnexal structures (sweat glands, sebaceous glands, & hair follicles) to the edges of the laser wounds. This migration of epithelial cells continues horizontally across the wound bed until the epithelial cells grow together. Next, the undifferentiated keratinocytes start the differentiation process, dividing and migrating upwards to recreate a new epidermis.

A moist environment will aid in keratinocyte migration during the healing process, therefore it is essential that the skin be kept moist until re-epithelialization is complete. Initially, some exudate is good which acts as a natural wound covering, provides the wound with nutrients and growth factors, controls infection, and supplies moisture to the wound all of which aids in the natural healing process. Nevertheless, if this biologic material is allowed to buildup (even if it is kept moist) it can eventually retard effective epithelialization, foster colonization of bacteria causing infection, resulting in slower healing and dermatitis.

If the exudate is allowed to dry out and form a crust or scab, it will impede healing even more, will increase pruritis (itching), and if peeled off prematurely, can lead to scarring. Patients should be refrained from inappropriately removing any crusting.

- **Moisturizing Process:** Exudate can be kept moist by applying copious amounts of topical moisturizer periodically (3 to 4 times a day minimum) or whenever the skin starts to feel dry.

Note: There is increased evidence that the proper use of emollients will dampen the immune reactions and lessen the degree of duration of post-op inflammation.

- **Soaks:** it is important to gently soak the treated tissue several times a day using a soft cloth saturated in plain water, saline, or hydrogen peroxide (alternatively, a dilute vinegar solution can be used as explained below).

This will help keep the skin moist, will aid in removing any exudate build-up (crusting) and will also allow the moisturizing ointment (applied immediately after soaking) to better penetrate the surface of the skin.

Note: At a minimum gently splash your face with warm water every few hours.

This needs to be done until all crusting has peeled off.

Vinegar Soaks: Gentle cleaning and soaking with a diluted vinegar solution (which is mildly acidic) will help dissolve any unwanted material from the wounded skin use, alleviate pain (soothing), promote healing, and inhibit bacterial growth (especially against pseudomonas and gram negatives).

Vinegar has a tonic action that promotes blood circulation in the small capillaries that irrigate the skin. It is also antiseptic, preventing the proliferation of bacteria, viruses, or yeast that trigger infection. It can dissolve excessive fatty deposits at the skin surface, dissolve and cleanse any necrotic material, and reduce scaly or peeling conditions. Lastly, vinegar regulates the pH of the skin.

This is just another weapon in your arsenal of things to use to improve the overall clinical outcome!

Vinegar soaks regimen: If vinegar soaks are used, they should be started in the morning on the day after surgery and continued until all crusting is gone and the skin has re-epitheliazied.

1. Thoroughly wash hands before touching the treated area (use antiseptic soap).
2. Prepare a water/vinegar solution as follows:
    a. Mix 1 ~~teaspoon (5 ml)~~ cup of cool tap water (some physicians recommend using distilled water) with 1 ~~cup (237 ml)~~ tsp of plain white vinegar. If this solution stings or burns, dilute vinegar solution by using 1 teaspoon to 2 cups (1 pint) of water. This solution may be mixed a head of time and put in the refrigerator. Prepare a new solution each time to prevent contamination.
3. Take a clean wash cloth (gauze pad or cotton swab) and soak it in the water/vinegar solution. Ring out any excess and then lay it over the treated area for 10 to 15 minutes. Do not rub vigorously but using the wash cloth you may gently remove (don't pick) any loose crusting.
4. When done soaking, gently pat the treated area dry with a clean soft towel. You can't soak too much. Soaking will reduce redness and speed healing. Note, you do not have to remove all of the moisturizer from off your face.
5. Next, reapply the cooling ointment generously.
6. Repeat this procedure 3 to 4 times daily until all crusting is gone.

The more aggressive the peel, the more benefit can be derived from using vinegar soaks. For very mild peels, vinegar soaks may not be necessary.

- **Once Re-Epithelialization is Complete** (skin is not broken, crusting phase has subsided, treated area is smooth, red and pink): soaks and ointments are discontinued, makeup and sunblock can now be applied and the patient can start using a mild moisturizer or post-laser healing cream.

Besides containing ingredients that moisturize, provide a barrier to outside contaminates, and promote healing to reduce recovery time, other qualities to look for in a post-laser skin care product are ones that are:

- ✓ fragrance Free
- ✓ colorant Free
- ✓ preservative free
- ✓ PH-balanced
- ✓ anti-inflammatory
- ✓ hypo-allergenic
- ✓ paraben free
- ✓ lanolin free

Other traits to look for in a post-laser resurfacing moisturizer are ones that:

- ✓ reduce edema (swelling)
- ✓ reduce erythema (redness)
- ✓ helps prevent weeping (oozing) and crusting (absorbs exudate)
- ✓ are non-comedogenic & protect against the formation of milia
- ✓ increase skin exfoliation
- ✓ resist bacterial contamination/infection
- ✓ increase collagen production
- ✓ reduce the risk of PIH
- ✓ and are soothing

Complex Moisturizers: If use of a complex healing ointment or cream is desired post-op (either immediately post-procedure or after re-epithelialization), there are numerous products to choose from, marketed specifically for use after laser treatment. Many of these moisturizers have been clinically proven to shorten tissue healing time.

Although not necessarily having all of the above traits, listed below is a sampling of some of the more common products on the market specifically designed to enhance healing after laser resurfacing, dermabrasion or chemical peel:

- ✓ **Protective Recovery Balm** by BiO_2 Cosmeceuticals
- ✓ **Post Laser Treatment Gel** by Regima® Skin Treatments
- ✓ **Post Laser Gel** by Visual Changes®
- ✓ **Biafine®** by OrthoNeutrogena
- ✓ **Cicalfate Restorative Skin Cream** by Avène
- ✓ **Z Calm Post Laser Revitalizing Cream** by Creative Technologies, Inc.
- ✓ **Post Laser Ointment** by Physicians Complex®
- ✓ **Res-Q** by One Stop Pharmacy Inc.
- ✓ **Donell Post-Procedure Ointment** by Donell Super-Skin
- ✓ **Complex CU_3® Intensive Tissue Repair Crème** by ProCyte Corporation
- ✓ **Laser Post Procedure Balm** by Elta MD™
- ✓ **Bio-restorative Skin Cream** by Neocutis
- ✓ **Rescue Post Treatment Crème** by Four Seasons Skin Care
- ✓ **Laserfade Post Laser Gel** by Hanson Skincare
- ✓ **Humatrix® Microclysmic Gel** by Care-Tech® Laboratories Inc.
- ✓ **Post Skin Resurfacing Balm** by DermaQuest™ Skin Therapy
- ✓ **pHaze 17 ReBalance** by PCA skin®
- ✓ **Post Peel Quick Recovery by** DLC Dermatologic Cosmetic Laboratories®
- ✓ **Clarifying Hydrate Conditioning Cream** by Glytone®

Note: Whether to use a post-laser treatment moisturizer or not, if so, which brand and when to start its application is a medical question each practitioner will have to make for themselves.

If a skin bleaching regimen was prescribed pre-op, it should not be resumed until at least 7 to 10 days post-op (or at first sign of PIH) in order to assure that the skin is sufficiently healed up.

Makeup: The patient can now apply water-based makeup. Purchase new application sponges or brushes. Infection or acne eruption can be due to accumulated bacteria.

Note: Patients should be warned that their skin will be more susceptible to irritation from makeup and hence it should be applied cautiously and conservatively. If irritation occurs they should switch to something less sensitizing.

Sunblock: Patients can now start using a full-spectrum (UVA & UVB) sunblock.

UVB radiation causes sun burn / UVA radiation causes an increase in melanoma & pigment change.

Do not use sunscreens since they absorb UV light and release it as heat into the skin. (There is some evidence that heal alone can lead to PIH.)

Rather, use sunblock which deflects or scatters (blocks) UV light.

Use sunblock with a SPF of 30 or higher. SPF is a universal measurement of how well you are protected from UVB radiation. No comparable standard exists for UVA radiation.

So for UVA protection, use a high quality sunblock containing one or both of the following ingredients: micronized titanium dioxide or zinc oxide of greater than 10%.

Also, do the following:

- ✓ Avoid all direct sun exposure for 3 – 5 days or until redness is completely gone.
- ✓ If patient must go outside, use sunblock of SPF 30 or higher
- ✓ Apply ½ hour before going outside for improved protection.
- ✓ Use sunblock for at least two weeks (3 – 6 mounts is better) after treatment any time outside in sun. (Sun avoidance and use of sunblock should be a life-long endeavor.)
- ✓ Use a mirror to apply sunblock evenly.
- ✓ Must be reapplied every 2 hours to be fully effective.
- ✓ Also use physical blockers such as hats, scarves and sunglasses when possible.

- **Elevate Head:** When sleeping the first night after treatment, elevate the head (or other treated area) using 2 – 3 pillows to reduce swelling.

- **Bath/shower:** The patient can shower or bath at any point in time post-operatively (although better to wait until the next day). Avoid hot showers or baths. Preferably take short warm showers. (Cold showers may be soothing and help remove heat). If you take a shower, avoid running hot water directly on the treated area. After bathing, gently pat dry the treated area with a soft cloth. Never wipe hard with a towel. Wash your hair everyday with baby shampoo (or other non-irritating shampoo) until completely healed.

- **No Hot Tubes, Jacuzzis, or Swimming Pools (with chemicals/chlorine) until redness is completely gone.**

- **No Strenuous Exercise:** Do not participate in any strenuous exercise (such as bending, squatting, straining, or heavy lifting) until all redness has completed resolved. Avoid activates that cause excessive perspiration. No contact sports.

- **Minimize Facial Expressions:** If the skin around the mouth is tight, minimize facial expressions until healed.

- **No Alcoholic Beverages:** Patients should avoid alcohol for 24 to 48 hours post-op (or until redness is gone).

- **Recovery process:** The recovery process will vary from patient to patient and on the level of treatment prescribed. On average, 5 – 7 days on the face, and 7 – 10 days off face (e.g., neck, décolletage, dorsum of the hands, arms, etc.)

  Note: Using more aggressive settings (or use of the 180 µm spot handpiece) may increase post-operative edema, erythema and recovery times from those stated above.

- **Post-treatment Photos:** Photos of the treatment area should be taken before the patient leaves the office post-op and during subsequent office visits to track the progress of healing.

- **Pain:** Other than a mild burning sensation for the first few hours, most patients experience no other pain. For mild pain, the patient can take acetaminophen (Tylenol or equivalent) for discomfort.

  Do not take aspirin or aspirin related drugs during the healing period.

  For moderate pain relief, stronger pain medication can be prescribed if necessary. Commonly used narcotics are listed below:

  - **Tylenol #3** (acetaminophen with codeine)
  - **Lorcet, Lortab, Vicodin** (hydrocodone with acetaminophen)
  - **OxyContin, Roxicodone** (oxycodone)
  - **Percocet** (oxycodone with acetaminophen)
  - **Darvon** (propoxyphene)
  - **Darvocet** (propoxyphene with acetaminophen)
  - **Demerol** (Meperidine hydrochloride)

  Note: Intense pain may be a sign of infection and in such cases the patient should be seen immediately.

- **Pruitis (itching):** Some patients experience a high level of itchiness for 2 – 3 days post-op.

  This is normally due to the release of histamines during the healing process, which can be explained to the patient as a good sign. (It could also be a sign of dry skin due to inadequate use of moisturizers).

  These patients can be prescribed 1% or 2.5% hydrocortisone applied topically once or twice a day for 2 days and/or an over the counter antihistamine (e.g., Benadryl). Remind the patient that taking an oral antihistamine can cause drowsiness.

- **Recommend the Long-Term Use of Anti-Aging and Collagen Promoting Skin Care Products:**

  The long term use of skin care products post-treatment that promote collagen formation (which peaks during the next 3 to 6 months) will aid in skin tightening and wrinkle reduction allowing more patients to achieve their desired cosmetic goal.

  When choosing a skincare product to promote anti-aging and collagen production, some of the ingredients to look for are:

  - ✓ Alpha Hydroxy Acid (AHAs) – should be at or above 8% to be effective
  - ✓ Beta Hydroxy Acid (BHAs)
  - ✓ Alph-lipoic Acid
  - ✓ Retinoids
  - ✓ Antioxidents –
    - Green Tea

- Pomegranate
- French Maritime Pine Bark
- Astaxanthin
- Ferulic Acid
- Prevage
- Cysteine
- Methionine
- Flavoniods
- Vitamin D3

✓ Kinetin
✓ Vitamin C - should be above 10% to be effective
✓ Vitamin E
✓ Copper Peptides
✓ Zinc Oxide
✓ Selenomethionine
✓ Soy-isoflavones
✓ Glutathione

- **Return office visit:** The optimal time to have the patient return for a check-up on the healing progress varies amongst practitioners; first return visit between days 1 – 3, and second return visit between days 7 – 10. Of course any indication from the patient that they are having some sort of adverse side affect will warrant an immediate office visit. Some physicians also recommend a revisit at 3 and 6 months post-procedure.

- **Possible Complications:** Have the patient call the office immediately if they have any fever, chills or pain after treatment that is not relieved by the prescribed pain medication. Also if they have excessive redness, blistering, swelling, bleeding, itching, yellow or cloudy discharge which could be a sign of infection. Increasing pain with deterioration in the appearance of the skin may also be the first signs of infection. Failure to diagnose and promptly treat these conditions may delay healing and lead to scarring.

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS
1327 Hemphill Street, Suite 100
Fort Worth, Texas 76104

NEW PATIENT GYN HISTORY

Today's Date:_____

Name:_____ **Primary Care Physician:**_____

Marital Status:_____ **Occupation:**_____

Reason for Visit/Complaint:_____

Current Medications:_____

Allergies:_____

MENSTRUAL HISTORY

Onset Age:_____ **Cycle Every**_____**Days** **Length:**_____**Days**

Last Menstrual Period:_____/_____/_____

- ☐ **Menopausal**
- ☐ **Hysterectomy**
- ☐ **Hysterectomy w/removal of ovarie**
- ☐ **Hysterectomy w/one ovary remova**
- ☐ **Ablation**

PREGNANCY HISTORY

TOTAL Pregnancies:_____ **Births**_____ **Living Children**_____ **Abortions**_____

Pregnancy Complications:_____

Current Contraception:_____ **Previous Contraception**_____

Problems w/Contraception_____

Last Pap Smear_____/_____/_____ **Results**_____

History of Previous Abnormal Pap Smear: YES/NO If Yes, When:_____/_____/_____

Treatment_____ **Follow-Up Treatment:**_____

Last Mammogram_____/_____/_____ **Results**_____

Last Bone Density _____/_____/_____ **Results**_____

SOCIAL HISTORY

			DETAILS
Alcohol	☐**Yes**	☐**No**	**Drinks per Week**_____ **Type of Alcohol**_____
Caffeine	☐**Yes**	☐**No**	**Drinks per Week**_____ **Type of Caffeine**_____
Tobacco	☐**Yes**	☐**No**	**Packs per Week**_____
Substance Abuse	☐**Yes**	☐**No**	**How Often**_____**Details**_____
Exercise	☐**Yes**	☐**No**	**How Often**_____
Occupation	☐**Yes**	☐**No**	_____

CHRONIC MEDICAL CONDITIONS:_____

_____

New Patient GYN History

MEDICAL HISTORY – Past & Present

- ☐ Anemia
- ☐ Asthma/Bronchites
- ☐ Blood/Black Bowel Movement
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gallstones
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hearing Problems
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Osteoporosis
- ☐ Other _____
- ☐ Problems with Muscles, Bones, Nerves, or Joints
- ☐ Psychiatric Problems
- ☐ Seizure Disorder
- ☐ STD_____
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thrombophlebitis/Blood Clot
- ☐ Thyroid Disorder
- ☐ Visual Disorders
- ☐ Vomited Blood

COMMENTS___:_____

_____

PAST SURGERIES (Please note the month & Year):_____

_____

SERIOUS INJURIES, ACCIDENTS, ILLNESSES:_____

_____

BLOOD TRANSFUSIONS (Please note the month & Year):_____

FAMILY HISTORY (check conditions which apply to grandparents, parents, siblings, or child)

- ☐ Birth Defects
- ☐ Breast Cancer
- ☐ Cancer, other
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Lung Problems
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Negative Family History
- ☐ Adopted
- ☐ Skin Disease
- ☐ Stroke
- ☐ Thrombophlebitis/Blood Clot
- ☐ Thyroid Problems
- ☐ Tuberculosis

PERSONAL GYNECOLOGICAL HISTORY – Past & Present:

- ☐ Vaginal discharge or irritation
- ☐ Difficulty getting pregnant
- ☐ Pain with intercourse
- ☐ Hot flashes/Menopausal symptoms
- ☐ Concern about STD Exposure
- ☐ Loss of Urine
- ☐ Pelvic Abnormality
- ☐ Frequent, prolonged, or heavy vaginal bleeding
- ☐ Urinary burning, frequency, or urgency
- ☐ Breast lump, pain, or discharge
- ☐ Low abdominal or pelvic pain or heaviness, low back pain
- ☐ Do you practice self breast examinations?

COMMENTS:_____

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

Jeff Hantes, D.O.
Director, Urogynecology
Texas Health Harris Methodist

Dear Patient, Name _____

We have recently adopted a new electronic health record system and no longer use paper charts. The transfer of information is a lengthy process and it is vital that we have all of the necessary information to better assist our patients. In doing so, we ask that you provide your pharmacy information in the space provided below. This will allow us to send your prescriptions in a timely manner and check for any possible drug interactions.

PHARMACY NAME: _____

ADDRESS: _____

CITY: _____

ZIP CODE: _____

TELEPHONE: _____

It is very important that we keep you medication list updated in our system. If there have been any changes in your medication since your last visit, please note below. Please circle whether you have begun a new medication or stopped taking a particular medication.

MEDICATION: _____ BEGIN/STOP DATE: _____

MEDICATION: _____ BEGIN/STOP DATE: _____

MEDICATION: _____ BEGIN/STOP DATE: _____

MEDICATION: _____ BEGIN/STOP DATE: _____

MEDICATION: _____ BEGIN/STOP DATE: _____

COMMENTS: _____

_____

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

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Confidential Patient Questionnaire

Please take a few moments to answer the questions below. Your feedback will help us to determine whether to offer our valued patients several of the country's most popular aesthetic and medical procedures. ***Please return to front desk after completing.***

Patient Name:_____ **Date of Birth:**_____

Email Address:_____ **Telephone:**_____

Are you interested in a new minimally invasive liposuction procedure that can be done in the office with minimal discomfort or downtime? Yes_____ No_____

Would you be interested in receiving CO_2 Fractional Laser Skin Resurfacing for the treatment of age spots, sun damage, enlarged pores, fine lines, wrinkles, stretch marks and acne scars? Yes_____ No_____

Would you be interested in an Incisionless Vaginal Rejuvenation procedure that uses a laser to create a smaller, tighter, more youthful vagina with normal anatomic contours? Yes____ No____ This procedure will help to restore the structure of the vagina which has been damaged from childbirth, aging, and/or previous gynecology surgery.

Are you interested in a physician directed weight-loss program that can help you lose 1 – 3 pounds per day? Yes_____ No_____

Would you be interested in Botox Cosmetic wrinkle removing therapy? Yes_____ No_____ If yes, which facial areas would you be interested in treating? Forehead _____ Crow's Feet _____ Frown Lines_____

Would you be interested in Juvederm treatments? Yes_____ No_____ If yes, which facial areas would you be interested in having treated? Smile Lines_____ Vertical Lip Lines_____ Lip Borders_____ Marionette Lines (lines at the corner of the mouth)_____ Other_____

Would you be interested in a permanent form of birth control that is gentle, hormone-free and can be done without cutting or the risks of getting your tubes tied? Yes_____ No_____

Do you suffer from heavy periods? Yes_____ No_____ If yes, would you be interested in learning more about an in-office procedure that can stop or significantly reduce heavy bleeding? Yes_____ No_____

Do you suffer from a loss of bladder control during physical activity such as coughing, laughing, sneezing or lifting? Yes_____ No_____ If so, would you be interested in learning more about a minimally invasive approach to treating this condition? Yes_____ No_____

Do you suffer from an overactive bladder? Yes_____ No_____ If you are waking up several times a night to use the bathroom, avoiding shopping trips and long walks or even scoping out public bathrooms whenever you leave home, then we have several treatment options available to you.

Do you experience pressure or discomfort in the vaginal or pelvic area, often made worse with physical activities such as prolonged standing, jogging or bicycling? Yes_____ No_____ If so, would you like to learn more about non-surgical and surgical options available to you? Yes_____ No_____

Would you be interested in Bio-Identical Hormone Replacement therapy to treat the symptoms of menopause including: hot flashes, weight gain, irritability, vaginal dryness, sleep disturbances and low libido? Yes____ No____

PATIENT REGISTRATION FORM

****Today's Date:** _____ **Clinic Name:** _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#:** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____) _____-_____

E-mail Address: _____ **Cell Phone #:** (_____) _____-_____

Emergency Contact Name: _____ **Emerg Phone #:** (_____) _____-_____

Please tell us how you heard about us: _____ ***Referred by*** _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient:** **Self**____ **Spouse**____ **Parent**____ **Other**_____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** **Female**_____ **Male**_____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

Insured's Social Security #: _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ **Eff Date:** _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

***Insured's Social Security #:** _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ *** Eff Date:** _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.** ***ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

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Financial Responsibility Agreement

Patient Name:_____ DOB:____/____/_____ Date of Visit: _____/_____/_____

I,_____, understand that I will be financially responsible for any and all charges for services not paid by my insurance visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-Ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance company will pay for my Medical service visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provided is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expenses to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I am also aware that there may be additional fees that are not covered by my insurance company. There will be a check fee of $25.00 for all returned checks. Failure to cancel a regular appointment with less than 24 hours notice or not showing for an appointment is subject to a $35.00 charge. Failure to show for an in-office procedure where adequate time has been set aside will result in a $50.00 charge. Also, completion of medical forms not covered by the insurance company is $25.00 for the first set and $10.00 for each additional set (FMLA).

Signature:_____ Date:_____

Print Name:_____ Witness:_____

TEXAS HEALTH MEDSYNERGIES
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____
Last Name First Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Texas Health MedSynergies or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health MedSynergies is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Texas Health MedSynergies or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the Texas Health MedSynergies. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health MedSynergies. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Health MedSynergies representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Health MedSynergies to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Texas Health MedSynergies physician or those under his/her supervision.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(if different from patient)

GUARANTOR NAME (Please Print):_____

HIPAA Notice of Privacy Practices

Female Health Associates of North Texas

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;
- The right to receive confidential communications concerning your medical condition and treatment;