THE CENTER FOR RESTORATIVE REPRODUCTIVE SURGERY

Office Policy

Welcome to the CRRS! We are pleased to be part of your healthcare team and will do all that we can to help you attain your goals. We care for, and about, you. To keep the lines of communication open we'll share our policies and expectations with you. Please note that as we grow, our policies may change.

Appointments: We do our best to honor appointment times but giving each patient individual care means we may sometimes run late. To help us stay on schedule, we ask you to arrive 15 minutes early for your appointment. If you must miss your appointment, please be courteous and let us know as soon as possible. Depending on the circumstances, you may be billed for a missed appointment.

Surgery: Our typical surgical fee is between $2000 and $10,000, determined before your surgery is scheduled. We cap our fee at $10,000 regardless of how complex the surgery is. A $1000 deposit is required to hold your surgery date. At or before your pre-op appointment, the remaining balance is due, but we have multiple financing options available to help you meet this requirement if needed. If you cancel surgery, your deposit is forfeited. If you reschedule, a $150 change fee is charged, but the deposit remains still intact. However, we understand that things happen. Talk to us, and we'll try to work something out.

Medications: Pain meds are prescribed to help with your recovery. We do not prescribe pain meds on an ongoing basis once recovery is complete.

Financial: You are responsible for payment for services received. The CRRS is not contracted with any insurance carrier and we will not be filing claims with your insurance. However, you may file a claim with your insurance on your own. If required, we will furnish you with an itemized statement after the surgery. How much your insurance company will cover depends on your individual policy. Any reimbursement by your insurance will typically be paid to you directly.

Paperwork: We provide an itemized statement after surgery so you can file the claim with your insurance carrier. We also provide copies of your operative and pathology reports. We will complete one set of FMLA paperwork for you. We do not charge for these services. Additional copies may have a processing fee attached.

Social Media: To protect your privacy as well as that of all our patients, we ask that you do not post any confidential information about your care online. Please reach out to us with any concerns. We are happy to help!

Questions & Emails: We encourage your questions as well as those of your spouse, parents, and friends. Please note that at times our emails may go to your Spam/Junk folder. You may receive emails from @rhmgyn.com and @thecrrs.com. Please save our email addresses and check your Spam/Junk folder when you are expecting an email from us.

We appreciate that you chose the Center for Restorative Reproductive Surgery, and we are glad to be on your team.

I have read, and understand, and agree to adhere to the policies above.

_____ _____

Printed Name **Signature** **Date**

CRRS PATIENT REGISTRATION FORM

How did you hear about us?	**Today's date:**
Name *(Last, First, M.I.):*	
Date of Birth:	**SSN:**
Primary reason for consultation: ☐ Fertility ☐ Pain ☐ Others (please specify)	
Address:	**Email:**
	Phone:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:	**Employer:**

Spouse / Significant others information	
Name *(Last, First, M.I.):*	
Phone:	**Relationship:**
Occupation:	**Employer:**
Is this person your emergency contact as well? ☐ Yes ☐ No (If No, please provide name, phone number and relationship of emergency contact below)	

Insurance Information: *I certify that, I, and / or my dependents(s) have insurance coverage with:*	
Insurance Carrier: ☐ PPO ☐ POS ☐ HSA ☐ HMO ☐ Other:	
Identification #:	**Group #:**
Claims Address:	**Insurance Phone:**
Name of primary subscriber *(Last, First, M.I.):*	
DOB:	**SSN:** **Relationship:**

Financial Responsibility: *Who is financially responsible for all charges whether or not paid by insurance?*		
Name *(Last, First, M.I.):*		
DOB:	**SSN:**	**Relationship:**

I certify that the above information is correct and that the Center for Restorative Reproductive Surgery (CRRS) has my permission to speak to the above named individuals in cases of emergency. If needed, I authorize the use of my signature on all insurance pre-authorization, submissions, etc. CRRS may also use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services if applicable. I understand that CRRS will not submit claims to my insurance carrier.

_____ _____

Printed Name **Signature**

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD (FRONT & BACK) AND A COLOR COPY OF YOUR PHOTO ID

CRRS NEW PATIENT QUESTIONNAIRE

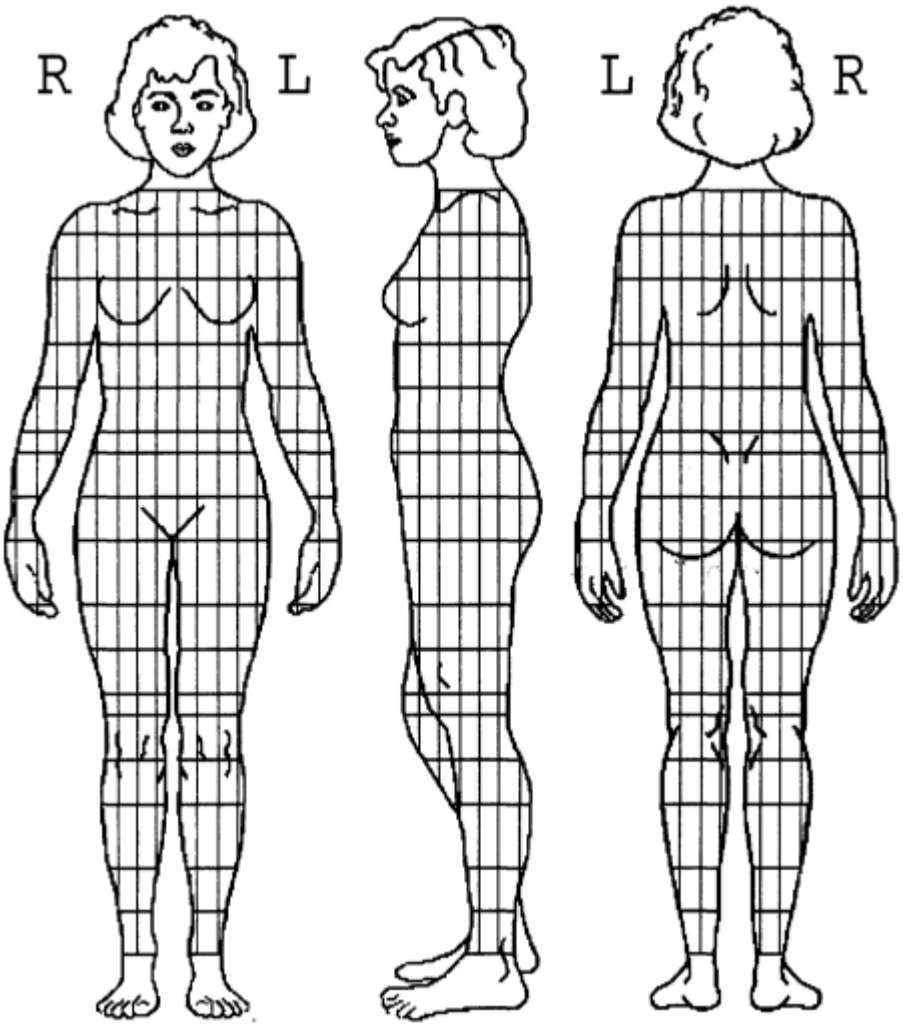
Name:	DOB:	Date:	Height:	Weight:

Modified International Pelvic Pain Society Questionnaire (Scale: 0-no pain, 10-worst pain imaginable)											
Overall pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain (not cramps) before period	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Ovulation (mid-cycle) pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain just before period	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Period cramps	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain after period is over	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain in groin when lifting	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with insertion during intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Deep pain with intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pelvic pain lasting for hours/days after intercourse	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain when bladder is full	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with urination	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain right after urination	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain at the flank / Kidney	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Lower back pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Muscle or joint pain	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with bowel movement	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of constipation	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of diarrhea	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of bloating	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Severity of intestinal cramping	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain with sitting	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain on neck / shoulders	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Pain underneath ribs	☐ N/A	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

More Information about your pain			
What type of treatments or providers have you tried in the past for your pain? *(Please check all that apply)*			
☐ Acupuncture	☐ Anesthesiologist	☐ Anti-seizure medications	☐ Biofeedback
☐ Botox injection	☐ Contraceptive pills / ring / patch	☐ Danazol (Danocrine)	☐ Depo-provera
☐ Gastroenterologist	☐ Gynecologist	☐ Family Practitioner	☐ Herbal Medicine
☐ Homeopathic Medicine	☐ Lupron, Synarel, Zoladex, e.t.c	☐ Massage	☐ Meditation
☐ Narcotics	☐ Naturopathic medication	☐ Nerve blocks	☐ Neurosurgeon
☐ Non-prescription medicine	☐ Nutrition / Diet	☐ Physical Therapy	☐ Psychological Counsellor
☐ Psychiatrist	☐ Rheumatologist	☐ Skin magnets	☐ Surgery
☐ TENS unit	☐ Trigger point injections	☐ Urologist	☐ Letrozole (Femara)
☐ Others:			

Pain Maps

Please shade **all** areas of pain. Indicate with a star the area where you experience the most pain

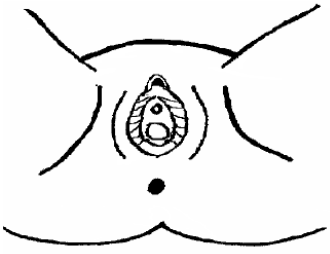


Vulvar / Perineal Pain
(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No

Right Left



Infertility Questions *(skip this section if you are NOT currently trying to conceive)*			
How many months have you and your husband tried to conceive?			
Are you working with any health care provider(s)? ☐ **No** *(We strongly recommend that you work with one)* ☐ **Yes** *(Please provide details)*			
Name	Specialty	Phone/Fax	Records mailed ☐ Y ☐ N
Name	Specialty	Phone/Fax	Records mailed ☐ Y ☐ N

Previous Fertility-Related Investigations: *(Please check if you have had any of the following and provide results from the most recent testing)*

Test	**Month/Year**	**Results and Comments**
☐ Ultrasound of uterus and ovaries		
☐ Ultrasound of the ovaries to look at ovulation (follicle tracking)		
☐ Hysterosalpingogram (X-ray assessment of the uterus and fallopian tubes)		
☐ Hysteroscopy (camera visualization of the uterine cavity)		
☐ Endometrial biopsy		
☐ D&C (scraping of the lining of the womb)		
☐ Post-coital test (looking at sperm taken from your cervix after intercourse)		
☐ Day 3 or early cycle blood test		
☐ Day 21 or late cycle blood test (progesterone/ovulation)		
☐ Other blood tests or investigations		

Previous Fertility-Related Diagnosis *(Please check if you have, or have had, any of the following)*

☐ Unexplained Infertility	☐ Recurrent Miscarriage	☐ Endometriosis	☐ Polycystic Ovaries (PCOS / PCOD)
☐ Low Progesterone	☐ Low Estrogen	☐ Not Ovulating	☐ Leutenized Unruptured Follicle (LUF)
☐ Fibroids in or on Uterus	☐ Pelvic Adhesions / Scar Tissue	☐ Abnormal Ovulation	☐ Hostile / Limited Cervical Mucus
☐ Polyps in Uterus	☐ Blocked / Damage Tubes	☐ Male Factor Infertility	☐ Adhesions in Uterus (Asherman)
☐ Others:			

Previous Fertility-Related Surgery *(Please check if you have had any of the following and provide the year(s) of the surgery)*

☐ Superficial treatment for endometriosis. Year:	☐ Excisional treatment for endometriosis. Year:
☐ Surgery for Uterine Polyps. Year:	☐ Fallopian tube reconstruction. Year:
☐ Ovarian surgery for Polycystic Ovaries. Year:	☐ Surgery for Fibroids (Myomectomy). Year:
☐ Others:	

Gynecological and Obstetrical History			
Age of first menses:	Age pelvic pain began:	Are you postmenopausal:	Are you trying to conceive:
What is your period like? ☐ Light ☐ Moderate ☐ Heavy		Period every days	☐ Regular ☐ Irregular
No. of pregnancies:	No. of live births:	No. vaginal deliveries:	No. of cesarean section:
No. of living children:	No. of miscarriages:	No. elective abortions :	No. ectopic:
Complications around delivery? ☐ Vacuum/Forceps ☐ Medication for bleeding ☐ Vaginal laceration ☐ Postpartum Hemorrhage			
Are you using any form of hormonal birth control currently? ☐ No ☐ Yes (what type)			
Did you have trouble getting pregnant? ☐ N/A ☐ No ☐ Yes – How long did you try before getting pregnant? months			
How did you achieve pregnancy? ☐ Spontaneous ☐ Ovulation Induction ☐ IUI ☐ IVF ☐ Other:			
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?			☐ Yes ☐ No
Date of your last PAP and results:			
Have you ever had these procedure (If so, please provide year)?	☐ Colposcopy	☐ LEEP	☐ Cone
Have you ever been diagnosed with sexually transmitted infection or pelvic inflammatory disease?			☐ Yes ☐ No

Current Health Care Providers *(physicians and non-physicians)*			
Name	**Specialty**	**Phone and fax number**	**Records attached?**
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
Current Pain Management Doctor:			☐ Y ☐ N

Medical History *(Please check if you have, or have had, any of the following)*			
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bladder disease
☐ Cancer	☐ Anxiety	☐ Chlamydia	☐ Chron's / Ulcerative Colitis
☐ Congenital Heart Disease	☐ Depression	☐ Deep Vein Thrombosis (DVT)	☐ Emphysema / COPD
☐ Epilepsy / Seizures	☐ Fibromyalgia	☐ Diabetes	☐ Glaucoma
☐ Gonorrhea	☐ Heart Attack (MI)	☐ Heart Murmur / Valve disease	☐ Heart Failure
☐ Hepatitis	☐ Heartburn / Reflux (GERD)	☐ Herpes	☐ HIV / AIDS
☐ HPV	☐ Hypertension	☐ Irritable Bowel Syndrome	☐ Interstitial Cystitis
☐ Kidney Disease / Renal Failure	☐ Kidney / Ureteral Stones	☐ Migraine Headaches	☐ Osteoporosis / Osteopenia
☐ Pulmonary Embolus (PE)	☐ Sickle Cell Disease / Trait	☐ Hemophilia	☐ Stroke
☐ Syphilis	☐ Thyroid Disease	☐ Trichomonas	☐ Tuberculosis
☐ Pneumothorax	☐ Hemoptysis (Cough up Blood)	☐ Pancreatitis	☐ Gallbladder disease / stones
☐ Others:			
Have you ever had a blood transfusion? ☐ No ☐ Yes		**Do you have any objection to blood transfusion? ☐ No ☐ Yes**	

Surgeries *(please list all your surgeries in chronological order starting with your first procedure)*

Month / Year	Procedure and findings	How much help did the surgery provide?	Surgical Report attached?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Surgical History *(Please check if you have had any of the following)*

☐ Single Ovary Removed	☐ Both Ovaries Removed	☐ Ovarian Cyst Removed	☐ Gallbladder Removed
☐ Cesarean Section	☐ Dilation and Curettage (D&C)	☐ Heart Surgery	☐ Hernia Repair
☐ Hysteroscopy	☐ Breast Surgery	☐ Appendectomy	☐ Cervical Cerclage
☐ Tubal Ligation	☐ Fallopian Tube(s) Surgery	☐ Fallopian Tube(s) Removed	☐ Tonsillectomy / Adenoidectomy
☐ Laparotomy (Open Surgery)	☐ Laparoscopy (Includes Robotic)	☐ Uterus removed (Hysterectomy)	☐ Vulvar Surgery / Biopsy
☐ Others:			
Any prior complications to anesthesia? ☐ No ☐ Yes (please specify)			

Review of Systems *(Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain)*

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Appetite:
☐ Lungs	☐ Circulation	
☐ Others:		

Medical History			
List your prescribed drugs			
Name the drug	Strength	Frequency	Reason
List your over-the-counter drugs, such as vitamins and supplements			
Name the drug	Strength	Frequency	Reason

Allergies to medications	
Name the Drug	Reaction You Had

Health Habits			
☐ **Alcohol**	What type of alcohol do you drink?	How many drinks per week?	
☐ **Tobacco**	If yes, how many packs of cigarettes per day?	For how many years?	Or years quit?
☐ **Drugs**	Do you currently use recreational / street drugs? ☐ Y ☐ N	Have you ever given yourself street drugs with a needle? ☐ Y ☐ N	
Comments:			

PLEASE PROVIDE YOUR NARRATIVE SUMMARY ON A SEPARATE SHEET OF PAPER

THE CENTER FOR RESTORATIVE REPRODUCTIVE SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S INFORMATION:

Name: _____ **DOB:** _____

Social Security Number: _____ **Phone Number:** _____ ☐ Mobile ☐ Home

Address: _____

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

I AM REQUESTING THE RELEASE MY MEDICAL RECORDS FROM:

Facility's Name: _____

Provider's Name: _____

Address: _____

Telephone: _____ **Fax:** _____

PLEASE SEND MY RECORDS TO:

FACILITY'S NAME: The Center for Restorative Reproductive Surgery

PROVIDER'S NAME: Nicholas Kongoasa, MD

ADDRESS: 3965 Holcomb Bridge Rd, Ste 100

CITY: Norcross **STATE:** GA **ZIP:** 30092

TELEPHONE: 770-450-8677 **FAX:** 678 792 8927

Please release a copy of all medical records, including Progress Notes, Operative Notes, Laboratory Results, and Diagnostic Tests.

Patient's Signature: _____ **Date:** _____

Patient's Printed Name: _____