Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Dear Friend:

My staff tells me you have scheduled a consultation to speak with me. I look forward to talking with you and discussing your desires regarding plastic surgery.

Below you will find your registration forms and medical history questionnaire which I request that you complete and send back prior to/bring in with you to our appointment. You may wish to write down questions you have so that we may address them in our consultation. When we speak we will have the opportunity to get to know one another and I will give you my honest professional advice about how to best achieve your plastic surgery goals. I want to provide you with the information you need to make the proper decision for yourself.

IF YOU CURRENTLY TAKE ANTI-INFLAMMATORY PRODUCTS OR MEDICATIONS, SUCH AS ADVIL OR ASPIRIN AND YOU PLAN ON HAVING SURGERY RIGHT AWAY, YOU WILL NEED TO STOP TAKING THEM AT LEAST TWO WEEKS PRIOR TO SURGERY. ADDITIONALLY, IF YOU ARE A SMOKER, YOU WILL NEED TO STOP SMOKING AT LEAST THREE WEEKS PRIOR TO SURGERY.

My staff and I look forward to and thank you for the opportunity to work with you and assist you in achieving your goals.

Sincerely,

Michael P. Goodman, M.D.

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Virtual Consultation Photo Instructions

Dr. Goodman needs **up close but in-focus photos** of your anatomy to accurately evaluate you for potential surgery. To achieve optimal photo quality, please either use a "selfie stick", have someone else take your photos or hold the camera at arm's length and then zoom in.

Each description below asks for a minimum number of photos but if you feel it necessary to send more, please feel free to do so. Additionally, you may also send a second copy of any photo you wish with edits (arrows or circles) to depict any specific bothers/concerns.

Labiaplasty/Clitoral Hood Procedures

Dr. Goodman needs a minimum of 5 photos. Photo #1 and #2 should be taken while sitting or lying down.

1. with your legs widely apart
2. with your legs just open enough to fit the camera/phone in between
3. should be taken laterally (from the left or right)
4. should be taken from the other lateral view (left or right)
5. should be taken while standing

Vaginal Reconstruction/Rejuvenation

Dr. Goodman needs a minimum of 3 photos. All photos should be taken while sitting or lying down. If you will be adding labiaplasty/clitoral hood reduction, please also follow the above instructions

1. should be taken with your legs just open enough to fit the camera/phone in between
2. with your legs widely apart
3. with your legs widely apart and you using your fingers to separate your labia and expose your vaginal opening as much as possible

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Appointment Policies

No Shows, Cancellations/Reschedules:

We understand that there are times when you must miss an appointment due to unavoidable circumstances, however, Dr. Goodman sets aside a considerable amount of time for each of his appointments. No shows and last-minute cancellations and reschedules leave open appointments that could have been offered to others who also need treatment.

All patients will receive a courtesy appointment reminder text and/or phone call (depending on the contact information we have on file) 7 and 3 days prior to their visit. We require 48 hours notice for all cancellations/reschedules.

*__Initial Surgery Consults__ will be charged $100 (half of the consult fee) at the time of scheduling and the remaining $100 will be due at the time of service. If you fail to show for your appointment/do not provide adequate notice for a cancellation/reschedule the $100 fee paid is non-refundable.

*__Revision Surgery__ (of another surgeon's work) __Consults__ will be charged $150 (half of the consult fee) at the time of scheduling and the remaining $150 will be due at the time of service. If you fail to show for your appointment/do not provide adequate notice for a cancellation/reschedule the $150 fee paid is non-refundable.

*__Established patients__ are given a grace of one no show or limited notice cancellation/reschedule per year. All subsequent instances will be subject to a $50 fee, which must be paid prior to being seen for your next visit.

Scheduled Appointments:

We understand that delays can happen, however we kindly ask that you notify the office if you are going to be running more than 10 minutes late for your appointment. We will always try to accommodate you; however when Dr. Goodman's schedule is fully booked, you may receive a shorter visit or need to be rescheduled.

Please be advised that there are NO EXCEPTIONS to this policy.

_____ _____

Patient Signature Date

Dr MICHAEL GOODMAN MD

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Summary of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one time acknowledgment that you have received this summary. A copy of the full Notice is available upon your request.

Your Rights As A Patient

You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes, to facilitate our being and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information

Disclosures Of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures Of Protected Health Information Not Requiring Your Authorization

We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Communication To You Of Confidential Information By Alternative Means

If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions To Use And Disclosure

You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access To Protected Health Information

You may request access to or a copy of your medical records in writing. We will provide these within the time period specified unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments To Medical Records

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting Of Disclosures Of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses Of Your Health Information

Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How To Lodge Complaints Related TO Perceived Violations Of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____, (printed name of patient or personal representative), acknowledge that Caring for Women or his duly authorized representative has provided a written copy of his Notice of Privacy Practices for protected Health Information to (check one) ◯ myself or ◯ specify: _____.

If you are signing as a personal representative, documentation of your legal right to do so must be provided.

_____ _____
Signature of Patient or Personal Representative — Date

_____ _____
Printed Name — Relationship to Patient

Dr MICHAEL GOODMAN MD

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

This section is for the use of the office of Caring for Women only

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____ _____

Signature of Representative Date

Self Pay Contract

Dr. Michael Goodman/Caring for Women Wellness Center is not associated with any insurance networks including Medicare, which means that they are not obligated to pay for any services rendered here. Payment in full at the time of service is required but if you choose, we will provide you with a "Super Bill" (a receipt showing that you paid out of pocket) with all pertinent information required for submission to your insurer for possible, (partial), direct reimbursement as per your "Out of Network" coverage benefit plan. We will not, however, communicate with your insurance company in any way. The form/receipt is your responsibility and serves as evidence of your treatment. We will not call, write, pre-certify or make any contact with your insurance company nor respond to any of their communications. If we receive a check from your insurance, we will return it to sender.

I hereby acknowledge and understand the above.

_____ _____

Patient Signature Date

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Patient Registration

Patient Information:

Last: _____

First: _____

Address: _____

City: _____ State: _____

Zip: _____

Phone #: _____

Work #: _____

Cell#: _____

Email: _____

Date of Birth: _____

Social Security #:_____

Marital Status: _____

Language: _____

Referral Source Name: _____ UPIN #: _____

Dr MICHAEL GOODMAN MD

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

I understand that I am financially responsible for all charges, whether they are paid by my insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of my benefits.

_____ _____
Patient Signature Date

Confidential Health Questionnaire

Patient Name Last: _____	 First: _____

I heard about "Caring For Women" from: _____
My usual healthcare provider is: _____
My occupation is: _____
Are you presently married or partnered? _____
Name of partner: _____
Partner's occupation: _____

HEALTH HISTORY:

Have you had any previous health problems related to the following areas? Check all the apply.

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

☐ Head, Eyes, Ears, Nose, Throat	☐ Skin, Hair, Nails
☐ Neck, Thyroid	☐ Back, Spine, Muscles, Bones
☐ Chest Respiratory	☐ Nervous System
☐ Heart, High Blood Pressure	☐ Psychological, Psychiatric
☐ Breasts	☐ Weight Problems, Eating Disorder
☐ Liver, Gallbladder, Hepatitis	☐ Chemical or Alcohol Dependency
☐ Kidneys, Bladder	☐ Reactions from Medications
☐ Stomach, Intestines (including constipation or diarrhea)	☐ Lymph Nodes / Anemia
	☐ Other Health Issues

If you've checked any of the above, please discribe:

_____

_____

_____

Please list all MEDICAL PROCEDURES (including plastic and cosmetic), surgeries, hospitalizations, serious injuries or serious medical problems you have had:

_____

_____

_____

Please list all MEDICATIONS you presently take (including vitamins, herbs and supplements):

_____

_____

_____

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Please list medications (as above) you no longer take, but have taken in the past 5 years:

_____
_____
_____

Please list any drug/medication ALLERGIES:

_____
_____

List any food/environmental allergies:

_____
_____

GYN SPECIFIC:

How many CHILDREN do you have: _____ What are their ages: _____ Have you had a miscarriage, and if so, how many? _____ Have you terminated a pregnancy, and if so, how many?_____	Do you have any grandchildren? _____ Do you LOSE URINE (Incontinence) when you don't want to? _____ Is it enough of a problem that you wish to do something about it? _____	Date of last period: _____ Date of last pap smear: _____ Date of last mammogram: _____ Date of last annual exam? _____

Have you taken HORMONES before?_____
If yes, what kind and what was your experience:

_____
_____
_____

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Please describe any present or past problems with your PERIODS:

_____
_____
_____

List all CONTRACEPTIVE methods and satisfaction (include surgeries such as tubal ligation and vasectomy):

_____
_____

Describe any present / past problems with your UTERUS, TUBES, OVARIES, VULVA, VAGINA:

_____
_____

Any past history of STD, recurrent herpes, HIV?_____
If yes, explain:

_____
_____

Are you significantly affected by cyclic PREMENSTRUAL SYMPTOMS?_____
If yes, please describe:

_____
_____

Is your SEXUAL LIFE : ◯ Fine or good ◯ Fair ◯ Unsatisfactory
Please comment:

_____
_____

Any problems with VAGINAL DRYNESS, vulvar pain or irritation?:

_____
_____

Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Does your partner have sexual or erectile issues? _____
Please explain:

_____

_____

What is the present state of your marriage/partnership?

_____

RISK ASSESSMENTS

Weight: _____ Height: _____ Ever smoked cigarettes? _____ Smoke now? _____ How much? _____ If you quit smoking, when? After smoking for how many years? _____	At what age did you have your first child? _____ Did you nurse your child(ren)? _____ Are you a "meat and potatoes" and dessert eater? _____ Are you mostly a grain and fruit / veggie eater? _____

Previous problems with cholesterol? _____
If yes, please describe:

_____

_____

Any family cardiac history? _____
If yes, please describe:

_____

_____

Please describe exactly what type/how much exercise you get on a weekly basis:

_____

_____

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Please list everything that you had to eat yesterday (breakfast — lunch — dinner — all snacks):

_____
_____

Any family members with BREAST, COLON, OVARIAN
CANCER?
Who, and at what age?

_____
_____

Have you ever been told you were at risk for any of these cancers? _____
If yes, please describe:

_____
_____

Have you ever had a breast biopsy? How many / results:

_____
_____

Any family history of osteoporosis?_____ Who? _____

Have you or any close family member ever been treated for depression? _____
If yes, please describe:

_____
_____

Do you work outside of your home? _____
If yes, please explain:

_____
_____

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

Have you had a problem with or been treated for fatigue? _____
If yes, please describe:

_____

_____

Any present or past situations of verbal, physical or sexual abuse? _____
If yes, please describe:

_____

_____

Does your work or home life expose you to excessive stress? _____
If yes, please explain:

_____

_____

Directions

- From 1-80 East (Towards San Francisco) or West, take Hwy 113 North towards Woodland.
- Exit at Russell Blvd. (2nd Exit), turn right at top of ramp.
- Turn left at the second stoplight onto Anderson Road. Davis Medical Center is about 1 block down on the left, just past the Sycamore Lane apartments. Turn left into the second entrance, park about 2/3 of the way down.
- We are in Suite 12B.

Dr MICHAEL GOODMAN MD

Caring For Women Wellness Center
Michael P. Goodman M.D., FACOG
635 Anderson Road, Suite 12B, Davis, CA 95616
Phone: (530)753-2787/ Fax: (530) 750-0221/ EMail: caring@dcn.org

FSFI Questionnaire

(Over the last 4 weeks)

_____ Patient Name

_____ Date

How would you rate your level of sexual desire or interest?		Very High 5 ○	High 4 ○	Moderate 3 ○	Low 2 ○	Very low or none 1 ○
How would you rate your level of sexual arousal during sexual activity or intercourse?	No sexual activity 0 ○	Very High 5 ○	High 4 ○	Moderate 3 ○	Low 2 ○	Very low or none 1 ○
How often did you become lubricated ("wet") during sexual activity or intercourse?	No sexual activity 0 ○	Very High 5 ○	High 4 ○	Moderate 3 ○	A few times 2 ○	Almost Never or Never 1 ○
When you had sexual stimulation or intercourse, how often did you reach orgasm?	No sexual activity 0 ○	Very High 5 ○	High 4 ○	Moderate 3 ○	A few times 2 ○	Almost Never or Never 1 ○
How satisfied have you been with your overall sexual life?		Very Satisfied 5 ○	Moderately Satisfied 4 ○	Equally Satisfied and Dissatisfied 3 ○	Moderately Dissatisfied 2 ○	Very Dissatisfied 1 ○
How often did you experience discomfort or pain during vaginal penetration?	No sexual activity 0 ○	Almost Never or Never 5 ○	A few times 4 ○	Sometimes 3 ○	Most times 2 ○	Almost Always or Always 1 ○