

# *Aesthetic Specialists of the Palm Beaches*

a subsidiary of Ob/Gyn Specialists of the Palm Beaches, P.A.

## CONSENT FOR SURGICAL PROCEDURE

I, \_\_\_\_\_,

give permission to Dr. \_\_\_\_\_,

to perform Labial Reduction Surgery upon myself.

I understand that this is an elective procedure which I have decided to have performed for cosmetic reasons. I further understand that there are potential risks involved. These risks include, but are not limited to, infection, bleeding, local skin reaction, anaphylactic reaction to anesthetic agents, bruising, blood clots and sepsis.

Complications may alter the cosmetic result and could require hospitalization for treatment. In rare instances, death may result. I recognize that I may not get the full cosmetic result that I am anticipating because there are individual differences in healing and physical characteristics. The procedure is performed bilaterally (on both sides of my body) and variations in healing could result in asymmetry (one side looking different than the other). I have had an opportunity to ask questions and all questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

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## *Labial Reduction and Revision Pre-op Instructions*

*Read and sign consent forms prior to procedure*

*Obtain any lab work requested by your physician*

*Do anti-bacterial wash the 2 days prior to the procedure*

*Nothing to eat or drink for 4 hours prior to procedure*

*Wear loose clothing to the office on the morning of your procedure*

*If you shave the area, do so 2 days prior to the procedure and not the morning of the procedure*

*Avoid ALL aspirin products and all non-steroidal products such as Aleve, Motrin, Ibuprofen for 2 weeks prior to procedure. If you have questions about a medication ask your doctor or the pharmacist*

*Stop all herbal products 2 weeks prior to procedure*

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## **PATIENT ACKNOWLEDGEMENT OF POSTED INSURANCE NOTICE**

I, (print full name) \_\_\_\_\_ acknowledge that I have seen the notice posted in the waiting room of Ob/Gyn Specialists of the Palm Beaches, P.A. and Perinatal/Gynecologic Specialists of the Palm Beaches, Inc. regarding malpractice insurance. The notice reads as follows:

*“Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.”*

### **YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE**

*This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.”*

*“This notice is provided pursuant to Florida Law.”*

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MR#:** \_\_\_\_\_

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## **NOTICE OF PRIVACY PRACTICES**

**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.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly **confidential**. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and client service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations.
- If we are required by law to treat you; or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

**You have recourse if you feel that your privacy protections have been violated.** You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Cathy Zalusky, COO  
OB/GYN Specialists of the Palm Beaches  
1515 North Flagler Dr., Suite 920  
West Palm Beach, FL 33401  
561-655-3331

For more information about HIPAA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

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## Patient Acknowledgement of Receipt of the Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Please **initial** each line and sign below to facilitate the processing of any necessary insurance forms and to acknowledge your understanding of our office payment procedures:

\_\_\_\_\_ I authorize the release of any medical information necessary to process my insurance claims.

\_\_\_\_\_ I authorize payment of medical benefits to Ob/Gyn Specialists of the Palm Beaches or Perinatal and Gynecologic Specialists of the Palm Beaches.

### RELEASE OF INFORMATION:

I authorize Aesthetic Specialists of the Palm Beaches a subsidiary of Ob/Gyn Specialists of the Palm Beaches to release information regarding my medical condition to the following people. (Please provide us with their names, relationship and phone number.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_ I authorize the request for any medical records to other health care providers for records necessary to my care.

May we leave the results of testing on your answering machine? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what telephone number? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Post-op instructions for Labial Reduction surgery**

1. Keep ice or frozen peas on labia for 10 minutes of every hour for the first 24 hours.
2. Avoid strenuous activity until cleared by your surgeon.
3. Avoid lifting, straining, bathing (showers are OK), or going into a pool, lake, or ocean until cleared by your surgeon.
4. Avoid driving for 1 week.
5. Avoid sexual activity until cleared by your surgeon.
6. Take medications as prescribed by your surgeon.
7. Notify your physician or call group immediately if you experience severe pain, excessive bleeding, excessive swelling, redness or fever.
8. Avoid wearing tight clothing for at least 2 weeks post-labiaplasty.
9. Tampons may be used if insertion is easy and pain free.