Dear Incoming Patient:

Enclosed is your new patient packet for the Southeast Vulvar Clinic. Please review and sign the forms where requested as well as answering all questions to the best of your ability. Once completed, please return ALL pages to us at your earliest convenience. You may send it back to us via US mail, scan and email it to svc@midcharlottederm.com or scan and fax it to 704-367-0504.

Failure to complete and return the packet in its entirety will slow your progress towards obtaining an appointment with Dr. Edwards.

Feel free to call or email with questions.

We look forward to working with you.

Referrals and Appointments
Southeast Vulvar Clinic
704-367-9777 ext. 8717

Tips for Vulvar Skin Care

While you are seeking treatment from us for your problem, here are some coping measures that might relieve symptoms and prevent further irritation. These irritants are not *causing* your symptoms, but they could be making them worse. As a woman with a history of vulvar symptoms, you should try these guidelines to prevent flares – even when you are feeling well. After your symptoms are under control, you can restart any habits that are important to you.

- Wash the vulva no more often than once a day, using water only; do not use a washcloth, but only soft fingertips.
- Avoid soap, douches, powders, over-the-counter medications (especially Vagisil or benzocaine) on this area.
- If any prescribed topical medications produce burning, stop using them and call your provider.
- Do not use panty liners, especially the brand "Always". If you have to use panty liners, Glad Rags may be less irritating, and can be ordered from gladrags.com.
- With periods, use tampons rather than pads if possible.
- Prevent constipation by adding fiber to your diet; an easy solution is one to two large helpings of a very high fiber cereal such as All Bran or All Bran Extra, with large amounts of fluid. Docusate 100 mg OTC gelcaps can be useful if used in an ongoing fashion, starting at one once or twice a day and increasing if needed. Miralax is another nonlaxative that is safe and often effective. Use these ongoing to prevent constipation.
- Apply ice, frozen peas, or a frozen blue gel pack (lunch box size) wrapped in a hand towel to relieve burning. But be careful not to overdo, since frostbite is a real possibility.
- Use a lubricant with sexual activity. Women with vaginal symptoms tend to be dry. Astroglide, Slippery Stuff, or vegetable oil (not K-Y) are good choices for a lubricant.
- Try applying A LOT of topical anesthetic (Xylocaine, lidocaine – NOT Vagisil) 30 minutes before sexual activity if sexual activity is painful for you.
- Contraceptive creams, spermicides and latex condoms can be irritating.

Let us know of any tips you have learned that we can pass on to our other patients!

SOUTHEAST VULVAR CLINIC

6406 Carmel Road, Unit 309, Charlotte, NC 28226
704-367-9777

Welcome to our office. We look forward to seeing you for evaluation of your genital symptoms. We hope this letter will make your visit as easy and beneficial as possible.

Enclosed you will find a patient information packet. This information is extraordinarily helpful to us in making a diagnosis and formulating therapy. Please answer these questions in your own words. Don't write "see my records" as medical records are often incomplete or illegible. I review your packets to ensure that your problem is one that I treat, and that there is not a dangerous problem we need to see immediately.

It is not necessary to send your entire medical history. Please call your referring doctor's office and inform them that I only need the medical records regarding cultures, wet mounts, molecular studies, and biopsies investigating your vulvovaginal problem. This may keep me from having to repeat procedures, which is especially important if you are traveling to see us and want to avoid a return trip for biopsy.

When we receive your completed packet and medical records, our referral coordinator will call to schedule your appointment. Because there are so many women with vulvovaginal skin diseases, our first available appointments are several months out. (*We will purge your records after three months if we do not hear from you*.)

Please follow these guidelines as these medications will interfere with evaluation in the office:

- **Avoid any antibiotics or anti-yeast medicines as well as any internal creams or suppositories *three days before your visit.***
- **Do not apply any creams or medications to your vulva *the day of your visit.***
- **Finally, if you are going to be menstruating on the day of your appointment, please call us so that we can move your appointment by a week or so. Menstruation fluids interfere with vaginal swabs and smears.**

Your symptoms may come and go. If you are doing well at the time of your visit, keep your appointment! Then, we will have a baseline evaluation, and we can see you quickly in the future if you are flaring.

If you have a rash or ulcers that you can see which come and go, and you feel perfectly fine in between outbreaks, be sure we are aware of this so we can schedule accordingly.

Enclosed are some tips for vulvar skin care that may be helpful until your visit.

A copy of your exam will be sent to you and to your referring physician. We suggest that we send copies of your office note to any other clinicians that may need to know this information. For example, if your gynecologist referred you, we suggest that you give us permission to copy your primary care provider as well. Please fill out the authorization form enclosed.

If you want us to be able to communicate with family members (regarding results of laboratory results, taking their phone calls, etc.) indicate your permission on the consent form.

We encourage you to bring your spouse or significant other with you – a woman's symptoms are not only her problem but a problem for both.

Please be on time; if you are late for this appointment, I will not have enough time to both diagnose and discuss your diagnosis and treatment plan with you.

There are very few providers who specialize in treating women who have chronic vulvar symptoms. For that reason, I have two goals in my office. The first, and most important, is to help patients. The second is to teach this area of medicine to other providers by lecturing, writing, research, and teaching in this office. Most likely, I will be accompanied by another clinician, usually a gynecologist or dermatologist; this may be a man or a woman. Photographs are routinely taken to help me evaluate for improvement and change in your condition as well as for teaching purposes.

Please be sure to review the important information about our insurance policy that we have included with this packet.

Because we are booked so far ahead and the need is so great, if you fail to keep your appointment or cancel your appointment giving less than 5 business days' notice, your account will be assessed a $100 fee.

If you are traveling from out of town, we are happy to provide a list of nearby lodging. Please call us if you have any questions or concerns. If you need to cancel your appointment with us, please give us at least five (5) business days' notice so that another patient may be able to take advantage of your cancellation. We look forward to your visit!

Sincerely,

Libby Edwards, M.D.

Please send a signed copy of this letter to our office indicating that you have read and understand this letter. Include the completed information packet, patient information form, and consent forms to the office.

_____ _____

Signature Date

Amended 3//22/22

IMPORTANT INFORMATION ABOUT INSURANCE

Currently we are contracted with Medicare (not Medicare replacement plans) and NC Medicaid. We do not participate with any other insurance plans.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE COVERAGE. Except for Medicare and Medicaid, payment is expected at the time of service. We encourage you to contact your insurance company and understand your benefits before your visit.

We will provide you with the paperwork to send to your insurance company for possible reimbursement.

The fees that you can expect for the initial consultation, if we do not file your insurance are:
99205 – Level V new patient visit **75 minutes**, Cost $495
Q0111 – Wet Prep, cost $20
Q0112 – KOH Prep, Cost $20
99354 or 99358 or 99417 or G2212 - time spent over 75 Minutes, Cost $95

Follow-up visits will range between $120 and $150.

We encourage patients to call if they are having issues. Calls to the office for quick issues such as medication refills will have no charge. However, calls which are more involved, such as phone consultations regarding medication issues, will be charged a $25 fee, though the first call is no charge.

Due to recent same day cancellations and no shows, we are instituting **$100 deposit** which will be applied to your visit bill. If you cancel this appointment with less than five business days' notice or do not keep your appointment, your deposit will not be refunded. We hope that this will allow us to see patients in a more timely fashion.

I have read and understand the above insurance and payment information

_____ _____

Patient Signature **Date**

Southeast Vulvar Clinic
6406 Carmel Road, Unit 309
Charlotte, NC 28226
704-367-9777

Consent for Treatment

Consent for Medical Treatment: I am asking for care and I agree to be given all necessary diagnostic tests, examinations, and surgical and medical treatments prescribed by the physician/provider treating me.

Authorization for Release of Medical Information: I give permission to release medical information about my treatment (including copies of my medical records) needed for payment of my insurance claim or for my continuing care after I have been treated. I reserve the right to revoke this consent at any time, and I understand that any revocation will be effective no earlier than the date of my notice.

Financial Agreement: I understand that as Southeast Vulvar Clinic does not file insurance claims that payment is expected at time of service. I understand that it is my responsibility to obtain the necessary approval for the provider's services, if my insurance requires precertification for those services. I understand that I am financially responsible for the amount of my bill.

_____ _____

Signature of Patient Signature of Responsible Party

_____ _____

Date Relationship to Patient

_____

Witness Signature

EDITED 3/22/2022

Southeast Vulvar Clinic/ Mid-Charlotte Dermatology
6406 Carmel Road, Unit 309, Charlotte, NC 28226

PATIENT INFORMATION				
Chart #	Today's Date	Sex M F	Marital Status	Race
Last Name:	First Name:	Middle Initial	Date of Birth	Social Security #
Street Address:		City, State & Zip		Home Phone #
Mailing Address:		City, State & Zip		Cell Phone #
Employer:		Employer's Address:		Work Phone #
Emergency Contact:		Relationship:		Phone #

SPOUSE/PARENT INFORMATION			
Last Name:	First Name:	Middle Initial:	Relationship:
Street Address:	City, State & Zip		Home Phone #
Employer	Employer's Address:		Work Phone#

INSURANCE INFORMATION					
Primary Insurance Company:			Secondary Insurance Company:		
Address:			Address:		
City, State & Zip:			City, State & Zip:		
Insured's Last Name, First Name and Middle Initial:			Insured's Last Name, First Name and Middle Initial:		
Relationship to Insured:			Relationship to Insured:		
Insured's Social Security #	Insured's Date of Birth		Insured's Social Security #	Insured's Date of Birth	
Policy Number:	Group Number:		Policy Number:	Group Number:	
Referring MD	Address:		Phone #	Fax #	

Insurance information is provided as a reference only. I understand and agree Dr. Libby Edwards does not participate with any insurance plans. I am ultimately responsible for the charges for any professional service I receive. I certify that this information is true and correct to the best of my knowledge. I am responsible to notify the practice of any changes.

Signature:	Date

Please attach a copy of your insurance card. We will **not** file your insurance, however the lab and/or pathology **will** file your insurance if any bloodwork or biopsies are done. You may receive a separate bill from the lab and/or the pathology.

Mid-Charlotte Dermatology
Southeast Vulvar Clinic

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Mid-Charlotte Dermatology/Southeast Vulvar Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to Mid-Charlotte Dermatology's notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the notice of privacy practices prior to signing this consent. Mid-Charlotte Dermatology/Southeast Vulvar Clinic reserves the right to revise its notice of privacy practices at any time. A reviewed notice of privacy practices may be obtained by forwarding a **written request** to 6406 Carmel Road, Unit 309, Charlotte, NC 28226.

I have the right to request that Mid-Charlotte Dermatology/Southeast Vulvar Clinic restrict how it uses or disclosed my personal healthcare information. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mid-Charlotte Dermatology/Southeast Vulvar Clinic's use and disclosure of my personal healthcare information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance up on prior consent. If I do not sign this contract, Mid-Charlotte Dermatology/Southeast Vulvar Clinic **may decline to provide treatment for me.**

With my consent, Mid-Charlotte Dermatology/Southeast Vulvar Clinic may discuss with:

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Physician/Healthcare Provider**
_____	_____
Name	**Primary Care Provider**

other elements of my condition as may be necessary to assist the practice in carrying out my healthcare and treatment needs.

_____ _____
Signature Date

_____
Print Name of Patient

_____ _____
Signature of Legal Guardian Print Name of Legal Guardian

SOUTHEAST VULVAR CLINIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

A COPY OF THIS FORM MAY BE USED IN THE SAME MANNER AS THE ORIGINAL

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) AS DESCRIBED BELOW:

I UNDERSTAND THAT IF THE PERSON OR ENTITY AUTHORIZED TO RECEIVE THIS INFORMATION IS NOT A HEALTHCARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL REGULATIONS, SUCH AS HIPAA, THE INFORMATION DESCRIBED BELOW ME BE RE-DISCLOSED BY SUCH PERSON OR ENTITY AND MAY NO LONGER BE PROTECTED BY REGULATIONS. I UNDERSTAND THAT I WILL NOT BE DENIED TREATMENT FOR REFUSING TO SIGN THIS FORM.

PATIENT INFORMATION				
Last Name:	First Name:	Middle Initial	Date of Birth:	Social Security #
Street Address:	City, State & Zip		Phone#:	

INFORMATION RELEASED TO/FROM	
Name/Company Name: Dr. Libby Edwards, Mid-Charlotte Dermatology/Southeast Vulvar Clinic	
Street Address: 6406 Carmel Road, Unit 309	City, State & Zip: Charlotte, NC 28226
Phone #: 704-367-9777	Fax #: 704-367-0504

INFORMATION RELEASED TO/FROM	
Name/Company Name:	
Street Address:	City, State & Zip
Phone #:	Fax #:

RECORDS TO RELEASE:			**PURPOSE OF RELEASE OF RECORDS**	
ALL INFORMATION (Entire record)			**CONTINUING TREATMENT**	**X**
OFFICE NOTES			**LEGAL INVESTIGATION**	
DIAGNOSES			**WORKERS COMPENSATION**	
LAB & PATHOLOGY REPORTS	**X**		**STAFF/PHYSICIAN ISSUES**	
DATES OF TREATMENT			**DISABILITY DETERMINATION**	
PROGRESS NOTES			**AT PATIENT'S REQUEST**	
OTHER (please specify)			**OTHER (please specify)**	

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW:

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE MID-CHARLOTTE DERMATOLOGY/SOUTHEAST VULVAR CLINIC OFFICES. REVOKING THIS AUTHORIZATION WILL NOT AFFECT DISCLOSURES MADE OR ACTIONS TAKEN BEFORE THE REVOCATION IS RECEIVED.

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: **DATE:**

NAME AND RELATIONSHIP OF AUTHORIZED REPRESENTATIVE:

SOUTHEAST VULVAR CLINIC

Libby Edwards, MD
6406 Carmel Road, Unit 309
Charlotte, North Carolina 28226
Phone: 704-367-9777
Fax: 704-367-0504

PATIENT INFORMATION PACKET
(Please respond to every question)

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Who referred you to see Dr. Edwards?_____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Please list all current medications that you take or apply to your skin, including birth control. (List additional medications on the back of this page, if needed.)

MEDICATION	DOSAGE	PURPOSE

Please list all allergies or medication intolerances. Write additional allergies on the back of this page if needed.

ALLERGY	REACTION

What is your vaginal/vulvar diagnosis, if it is known? _____

When did the problem for which you are seeing Dr. Edwards first begin? _____

What are your vaginal/vulvar symptoms (itching, burning, rawness, pain with sexual activity, etc.)? Please give us as much detail as possible. (Use the back of this page if necessary.)

_____
_____
_____
_____
_____
_____

If you are itchy, is this an itch that makes you want to rub and scratch? **YES** **NO**

If you rub or scratch, does it feel good at first? **YES** **NO**

Has it been a constant problem? **YES** **NO** Does it "come and go"? **YES** **NO**

Do you ever have pain/burning/rawness or soreness when nothing is touching or recently has touched the area? **YES** **NO**

Have you noticed anything in particular that worsens this problem? **YES** **NO**
If yes, what?

_____
_____

Do your symptoms interfere with your sleep? **YES** **NO**

If you are sexually active, do you have pain with intercourse or sexual activities? **YES** **NO**

Have you ever experienced comfortable sexual activity? **YES** **NO**

Please list all treatments, both prescription and non-prescription, that you have used for this problem. (Please do not say "see my records".) You may need to call your pharmacy for names of medications. You can use the back of this page if needed.

List of treatments/medications	Better	Worse	No Change

What are you using right now on your genital skin for washing, lubrication, treatment or for any other reason? Please list **any** soaps, douches, vaginal washes, powders, moisturizers, colognes, sprays, creams, ointments, etc.

_____

_____

How often do you wash this area? _____

If you have periods, do you use: Tampons _____ Pads _____

Do you use panty liners? **YES NO**

Has anyone in your family had chronic genital pain, burning, rawness or itching as far as you know? **YES NO** If yes, who and what? _____

Have you had a vulvar biopsy? (A piece of skin removed from your genital area and sent to a laboratory). **YES* NO**

What year? _____ Physician's Name: _____

Physician's Phone Number: _____

* If yes, please request from the ordering physician that the biopsy report be sent to our office.

Please list all surgeries	Year Done

Have you had any of the following?	Yes	No
Abnormal Pap Smear (If yes, when and what was done?)		
Genital Warts		
Genital Herpes		
Shingles (If yes, where on your body?)		
Diabetes		
Eczema		
Psoriasis		
Allergic Rhinitis		
Asthma		
Chronic Sinus Problems		

Have you ever been in the hospital for reasons other than surgery or childbirth? **YES** **NO**
If yes, for what reason? _____

When was your most recent pregnancy? _____

Have you breast-fed a child in the past eight months? **YES** **NO**
If yes, when did you stop? _____

Have you been through menopause? **YES** **NO** **Year** _____

Circle if you have any problems with the following:

General: energy levels depression anxiety sleep issues headaches

Gastrointestinal: constipation diarrhea heartburn difficulty swallowing

Bladder: urinary frequency burning leakage urgency

Mouth: pain sores

Eyes: dryness pain stinging

Musculoskeletal: back pain joint pain

Have you ever been diagnosed with (circle please): irritable bowel syndrome

fibromyalgia interstitial cystitis chronic fatigue syndrome pelvic pain

temporomandibular joint disorder other pain syndrome _____

Do you have any other medical illnesses we have not included? **YES** **NO** (If yes, please list).

_____

_____

What do **you** think may be causing the problem?

_____

_____

_____

Do you have any fears or worries concerning this problem? **YES** **NO** If yes, what are they?

_____

_____

_____

Have you ever considered committing suicide over this condition? **YES** **NO**

Is there anything else you feel that we should know? **YES** **NO** If yes, what?

_____

_____

_____

_____

Preferred Pharmacy Name and Phone#_____

For office use

Provider's Signature: _____

Libby Edwards, M.D.

Last revised: 4/25/2018