

**CENTER FOR VULVOVAGINAL DISORDERS**

**REGISTRATION**

**Andrew T. Goldstein, M.D., FACOG**  
**Lara J. Burrows, M.D., MSc, FACOG**

3 Washington Circle NW  
Suite 205  
Washington, DC 20037-2326

48 East 43<sup>rd</sup> Street 7<sup>th</sup> Floor  
New York, NY 10017  
\*For Directions to the NY Office,  
please call 212-599-4400

2002 Medical Parkway  
Suite 205  
Annapolis, MD  
21401-3260

Tel. (202) 887-0568 • Fax (202) 659-6481

**Appointment Date:** \_\_\_\_\_

***Patient Registration – Please Print Clearly***

Patient Name			First	Middle	Last	Date of Birth		Age
Home Address				Apt. No.	City		State	Zip Code
Occupation		Social Security No.		Marital Status		Sex	Home Phone	
				<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W			Cell	
Employer			Address				Work	
							Email	
Spouse's Name (or Parent)			Spouse's Employer (or Parent)			Preferred method of communication		
Spouse's or Parent's Address						Spouse/Parent Work Phone		
Referred By			Address				Telephone	
Preferred Pharmacy						Preferred Pharmacy Phone		

**Emergency Contact Information**

<b>IN CASE OF EMERGENCY, PLEASE NOTIFY:</b>		
Name _____		Relationship _____
First	Middle	Last
Home Phone _____		Work Phone _____
Address _____		

**Policy Concerning Payment of Medical Bills**

Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance pays in full, a portion, or nothing at all for services is a matter between you and your insurance carrier. Payment is accepted in the form of cash, check, money order, or charge card. The patient agrees to pay a \$250 cancellation fee if the appointment is not cancelled or rescheduled 2 business days prior to appointment time. In order for the appointment to be confirmed, office calls must reach the patient or the patient must return the call at least one day prior to appointment.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# Center for Vulvovaginal Disorders

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September 19, 2011

## Your First Appointment:

New patient appointments are approximately 1 hour and fifteen minutes, but we ask that you set aside 2 hours in the event that your appointment requires more time. If English is not your primary language, we advise you to bring someone with you to translate and assist you throughout the appointment, as needed. Please contact our website ([www.cvvd.org](http://www.cvvd.org)) for all required forms and directions.

## Cancellation Policy:

CVVD requires two business days of notice if you need to cancel or reschedule a new patient appointment. As indicated when scheduling your appointment, we use a credit card number to hold the appointment and nothing is charged to the card as long as two business days are given upon cancelling or rescheduling. The charge for any appointment cancelled without giving two business days notice is \$250.00, which will be credited towards your rescheduled appointment. All notifications with regard to cancelling and/or rescheduling appointments must be reported by phone to 202-887-0568 x101.

## Insurance and Payment Policy:

The Center for Vulvovaginal Disorders offers its patients comprehensive health care which limits our ability to work within the limitations of the health insurance industry. Due to this, we do not accept insurance, Medicaid, Medicare, or Tricare nor do we accept assignment file or coordinate insurance reimbursements. Please note that while filing of insurance claim for reimbursement is the **patient's responsibility**, you will receive at the time of check-out a complete, itemized receipt that you may use to immediately file with your claim for reimbursement.

The average cost for a new patient appointment is \$1300.00. This cost reflects the consultation, exam and all lab work performed during your visit; actual costs may vary depending on the amount of lab work performed. Payment, in full, is required at the time of service. We accept all major credit cards, cash, and check.

## Required Paperwork:

Upon scheduling your appointment, please visit our website and fill out the two-page registration form. You can either email it to [cvvd.dropbox@gmail.com](mailto:cvvd.dropbox@gmail.com) or fax it to 202-659-6481. Please note that this form must be received by our office within 24 hours of scheduling your appointment with us. If you are unable to return this document to our office within the specified time, please contact our office to discuss alternatives. If arrangements are not made and we do not receive the document, we reserve the right to release your appointment. In addition, please fill out the seven-page Vulvar Pain Questionnaire and bring it with you to your appointment.

\*If you carry either Tricare or Medicare please visit our website and download and complete all necessary waivers and bring them to your appointment. As mentioned above, we do not accept assignment from Medicare or Tricare. By signing this form, you are acknowledging that you have read and understand the aforementioned scheduling procedures and payment policy.

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Signature

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Date