SOUTH COAST
UROGYNECOLOGY

AVS Quote & Payment History

Name: _____ Quote Date: _____
Account#: _____ Paid in Full Date: _____
Surgery Date: _____ Financial Responsibility: Cash Patient or Insurance: _____

Quote by: _____

PROCEDURE	CODE	PRICE
ANTERIOR REPAIR		
CLITORAL HOOD REDUCTION	58999	
CYSTOSCOPY/SLING		
ENTEROCELE REPAIR		
HEMORRHOIDECTOMY		
HYMENOPLASTY	56700	
LABIAPLASTY MAJORA	15839B	
LABIAPLASTY MINORA	15839A	
PERINEOPLASTY	56810	
POSTERIOR REPAIR		
VAGINAL VAULT SUSPENSION		
VAGINOPLASTY	56800	
MESH		
OTHER		
NEOCUTIS	NEOBC1	
NUMBING CREAM	NUCRM	
SURGERY CENTER/HOSPITAL		
ANESTHESIOLOGY		
Subtotal		$
Disc _____%		
Total		$

TOTAL MUST BE PAID BEFORE SURGERY

50% Deposit	$	Date:
Cash Check# CC: Amex/MasterCard/Visa/Discover/CareCredit			
Balance Due	$	
2nd Payment	$	Date:
Cash Check# CC: Amex/MasterCard/Visa/Discover/CareCredit			
Balance Due	$	
3rd Payment	$	Date:
Cash Check# CC: Amex/MasterCard/Visa/Discover/CareCredit			
Balance Due	$	
4th Payment	$	Date:
Cash Check# CC: Amex/MasterCard/Visa/Discover/CareCredit			
Balance Due	$	

Acknowledgement
I have reviewed the procedures and costs of the surgery to be performed and accept financial responsibility for the balance due.

I would like / I would not like to be considered as a patient during surgeon training days.

Patient Name (print name) Signature Date