Bay Area Reconstructive Healthcare

345 Lorton Ave, Suite 101, Burlingame, CA
Ph: (650)570-2270 Fax: (650)570-2283

Patient Registration

When you are ready to schedule surgery, please submit your non-refundable $1,000 surgery deposit by calling our office at (650)570-2270. Alternatively, you may send a check to P.O Box 1044, Trinidad, CO, 81082. All checks should be made out to Marci L. Bowers, MD.

If you are scheduling a revision, reopening procedure, deepening procedure, or if you have ever been placed on puberty blockers, transitioned before turning 18, or have any concerns about having enough tissue, please call our office at (650) 570-2270 to schedule an in-person consultation.

Patient Name: _____

(Patient Legal Name if Different): _____

Pronouns: ☐ She/her ☐ He/him ☐ They/them ☐ Other _____

Date of Birth: _____

Patient Email: _____

Phone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Height: _____ Weight: _____

HIV Status (If HIV positive, must show undetectable viral load & CD4 of <400 within 60 days of surgery)

☐ Positive ☐ Negative ☐ Unknown

Smoker:

☐ Yes ☐ No

Surgery criteria/requirements for Bay Area Reconstructive Healthcare include a BMI limit of 40. Patients must also be non-smokers as there is an increased risk of healing-related complications that are associated with smoking. If you cannot meet these criteria, please consider postponing your surgery. Contact our office at (650)570-2270 if you do not meet these requirements.

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Date of Initial Social Transition (if applicable): _____

Date of Initial Hormone Therapy (if applicable): _____

Endocrinologist or Primary Physician's Name: _____

Endocrinologist or Primary Physician Phone Number: _____

Emergency Contact: _____

Relationship to Patient: _____

Phone Number: _____

Letters of Recommendation are required for GAV, orchiectomy, some FFS surgeries, and BA. Letters of recommendation are not required for labiaplasty, clitoroplasty, tracheal shave, etc. We understand you may have yet to arrange for Letters of Recommendation when applying for surgery. If you know the professionals who will provide you with letters, please list their information below.

Letter of Recommendation #1

Provider: _____

Contact Information: _____

_____

Letter of Recommendation #2

Provider: _____

Contact Information: _____

_____

Would you like a Notarized Surgical Declaration Letter mailed to you after surgery?

☐ Yes ☐ No

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Please select the procedure(s) you are interested in:

Inpatient

- ☐ Gender Affirming Vaginoplasty
- ☐ Vaginal Deepening Procedure
- ☐ Zero Depth (ZD) Vaginoplasty
- ☐ Hysterectomy

Outpatient

- ☐ Labiaplasty / Urethromeatoplasty
- ☐ Tracheal Shave
- ☐ Breast Augmentation
  - ☐ with implants
  - ☐ with fat grafting
- ☐ Orchiectomy
  - ☐ with removal of scrotal tissue (if not considering future vaginoplasty)
- ☐ Vaginal Reopening Procedure
- ☐ Facial Feminization Surgery
- ☐ Simple Metoidioplasty
- ☐ Scrotoplasty and Testicular Implants
- ☐ Chest Masculinization

☐ Other (Please provide more information:

_____

_____

_____

What is your target date or timeline for surgery? _____

_____

_____

Which surgeon(s) would you like to schedule with?

☐ Dr. Bowers

☐ Dr. Gunther

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Insurance Information

Please provide ALL insurance ID cards and information, regardless of expected coverage of each plan. If you do not provide us with all your insurance information, you may be responsible for full charges after your visit/surgery, even if we have authorization.

Please check one of the following:

☐ Bill Insurance ☐ Do Not Bill Insurance

*(*If Medicaid/Medicare/Medical is your primary insurance provider, we are unable to bill them - please select "Don't Bill Insurance". Currently, we do not accept Medicare, Medicaid, or Medical for services. Our office will collect out-of-pocket for patients with Medicare, Medicaid, and Medical.)*

Do you have Medicare?

☐ Yes ☐ No

Do you have Medicaid or Medical?

☐ Yes ☐ No

Gender on Insurance: _____

Primary Insurance Company Name: _____

Insurance ID: _____

Group Number: _____

Phone Number: _____

Secondary Insurance Company Name (if applicable): _____

Insurance ID: _____

Group Number: _____

Phone Number: _____

Primary Insured Person Full Name (if not self): _____

Relationship to Patient: _____

Date of Birth: _____

Social Security Number: _____

Phone Number: _____

Address (if different from patient): _____

Insurance ID: _____

Group Number: _____

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Signing this application verifies your consent to participate in current and future research studies regarding surgery with Dr. Marci Bowers and/or Dr. Sven Gunther, which may include pre- and post-operative experiences and outcomes. These studies intend to educate the public further and publish quality research data. Study information will maintain confidentiality and disclose as little personal information as possible while remaining compliant with the law and university policies (if applicable). No unique identifiers of participants will be published or presented. You can withdraw your permission to use and share your health information at any time. If you wish to do so, you must inform the office staff. Your decision to participate in education/research endeavors will not affect the quality of your care.

Terms of Acknowledgement

I authorize the release of any medical information necessary to process this claim to insurance. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Bowers and/or Dr. Gunther to apply for benefits on my behalf for covered services rendered by her/him or her/his order. I request that payment from my insurance company be made directly to Dr. Bowers/Dr. Gunther (or to the party who accepts assignment).

I certify that the information I have provided regarding my insurance coverage is correct. If all active insurance information is not provided, I understand I may be responsible for full charges after my office visit/surgery, even if pre-authorization is approved. This authorization may be revoked by either myself or my insurance company at any time in writing.

Acceptable forms of payment include cash, check, credit, or debit cards. If I visit Dr. Bowers or Dr. Gunther for a consultation, I will pay the full amount at the time of service. Consultation fees are not applied to future surgery fees. My insurance will be billed following the consultation and I may be reimbursed the amount, except any coinsurance, copays, or fees described by my insurance plan for specialist visits. For services other than consultation, a co-pay (or payment in full if I do not have insurance) is due at the time of service.

To hold a place on the surgery schedule, Bay Area Reconstructive Healthcare requires a non-refundable $1000 surgery deposit. If I am offered a specific date and confirm my availability, and I cannot have surgery on the agreed upon date for any reason, I may need to provide another non-refundable $1000 surgery deposit to reschedule. This fee is non-refundable unless rare, exceptional conditions arise and are negotiated with senior management. I acknowledge that by signing this application I agree to Bay Area Reconstructive Healthcare's non-refundable surgery deposit policy.

By signing below, I acknowledge that the above information is true and correct to the best of my knowledge, and that I have received and read the HIPAA Notice of Privacy Practices if I requested them.

Print Full Legal Name: _____

Signature:_____ Today's Date: _____

Print Full Name of Parent/Guardian (for patients under 18): _____

Signature:_____ Today's Date: _____