DERMATOLOGY AND LASER CENTER

OF OKLAHOMA

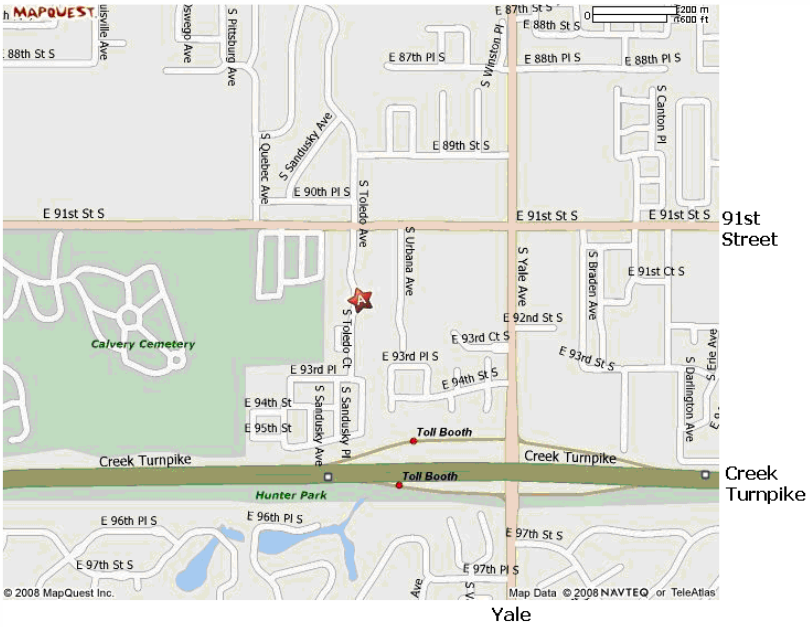
Dear Patient,

You are scheduled to have Mohs Micrographic Surgery on ____at _____. Below is a map with directions to our office. Please look over the attached information sheets and call our office with any questions you might have.

Please complete all paperwork and mail back if possible, otherwise bring it with you to your appointment.

Important Information:

- Please **take a picture** of the biopsy site with your phone and bring it to your appointment.
- If your biopsy site cannot be identified on surgery day, your procedure will be deferred to another day.
- If you are unsure where your biopsy site is located, contact our office immediately to schedule a consultation.



Directions: Our office is located on 91st Street between Yale and Harvard in Ashton Creek office park (you will see a clock tower at the entrance of Ashton Creek). Once you have entered the medical office complex, you will drive straight until you come to Toledo Court. This will be the last right-hand turn before the neighborhood.

Providers

Mary Christian Reed, MD
Jacqueline Guidry, MD
Brianne Smith, PA-C
Kristyn Lewis, RN, BSN

Address

9306 South Toledo
Court, Suite 100
Tulsa, OK 74137

Contacts

918-494-0400
918-876-3437
www.dermatologylaserok.com

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WHAT TO EXPECT ON YOUR MOHS MICROGRAPHIC SURGERY DAY

- If your skin cancer is near your eyes, you need to have someone drive you to your appointment.
- You will arrive 15 minutes before your appointment to finish all your paperwork.
- A nurse will bring you to your room and will have you sign a consent form, take your blood pressure and measure your skin cancer. A short video about the procedure may be shown.
- Dr. Reed will come to talk to you. At this time, she will answer any of your questions.
- You will NOT be put under using general anesthesia. Dr. Reed will use local anesthetic to numb the area where she will be working.
- Dr. Reed will go around and underneath the visible skin cancer to remove it. This removal is called a "layer".
- Once the layer has been removed, it will go to our lab on site.
- The layer will be processed in the lab for 1 to 2 hours depending on the size. You will be waiting during this time. You may wait in your exam room or in our waiting area.
- Dr. Reed will then look at the layer under her microscope to determine if all the cancer is gone.
- If the cancer is gone, she will discuss repair options and close the wound. If there is still cancer present, a second layer of tissue will be taken and sent to the lab. Most people need two layers to be taken off before the cancer is gone.
- Sometimes a plastic surgeon can do the closure. If you want this, please let us know in advance. A different appointment with a plastic surgeon will need to be scheduled before you come in for your surgery.
- You will be in our office for 4-6 hours, possibly longer if your cancer site is large.
- After the repair a scar will develop, but we will help you in making sure you are comfortable with how it looks.

What happens if I don't treat the skin cancer?

- It will continue to grow. This could turn into a large, painful wound or tumor. It could damage nearby organs (like your eyes), or continue to grow down into the bone.
- It could possibly spread to other areas of your body and possible death.

Things to avoid?

- Hair products.
- Favorite clothing because of blood or solvents to be used.
- Jewelry near the site of treatment.
- Makeup or skin products on or near the area to be treated.

Things to Remember:

- Bring your completed patient forms.
- Bring Lunch (or someone can bring you something).
- Bring things to do while waiting (ex: book, magazine, game).
- We have WiFi (wireless internet).
- Wear comfortable clothes (Something warm if you tend to get cold).
- Bring a blanket or pillow (if you wish).
- Make sure to take your medications as usual, and if needed, bring them with you.

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Medication and Exercise Instructions

- **PRESCRIPTION MEDICATIONS**
  - **DO NOT STOP** taking any prescribed medications, even blood thinners.
  - **Warfarin/Coumadin prescriptions ONLY PATIENTS:**
    - **DO NOT STOP,** even if you have been advised to in the past for previous surgical procedures.
    - **IF YOU ARE ON WARFARIN/COUMADIN**: Your INR must be checked within one week of your surgery. If you fail to do so, your surgery will have to be re-scheduled
    - Please bring your INR results with you to your surgery appointment or have it faxed to our office.
- **ASPIRIN**
  - **DO NOT STOP** taking your Aspirin without consulting your prescribing physician.
- **EXERCISE**
  - Exercise will be restricted after surgery from 1 week to 2 weeks. Your provider will go over this information on the day of your procedure.
- **1 WEEK BEFORE PROCEDURE DATE**
  - Tylenol is preferred for over the counter pain relief, if needed.
  - Stop all vitamins and supplements such as multi-vitamin, fish oil, etc.

Patient Signature: _____ Date: _____

If you have any questions, please contact our office to schedule a consultation.

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Patient Information Sheet

Patient Name_____
Last **First** **Middle** **Preferred Name**

Date of Birth _____ **Married** __ **Single** __ **Divorced** __ **Widow** __ **Other** __

Language_____ **Race**_____ **Ethnicity:** Hispanic / Latino / None

Primary Phone: _____ **Circle one:** Home / Work / Cell **Voicemail Allowed:** Y / N

Secondary Phone: _____ **Circle one:** Home / Work / Cell **Voicemail Allowed:** Y / N

Test Results/Biopsy Results
To assist us in getting any test results to you, do you authorize anyone other than yourself to receive your test results and discuss your condition with when we call the phone numbers that you have provided?
Please circle one **YES** **NO** If YES; please list their name(s) **and relationship(s)**

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Email Address: _____

Street Address_____

City _____ **State** _____ **Zip** _____

If Insurance is under a different name than patient, include the following information:

Subscriber Name:_____ **Date of Birth:** _____

Social Security (if required for insurance)**:** _____

Pharmacy: _____ **Address/Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Smoking Status: Current / Past / Never

Pts < 18 years old: Authorized signature to see minor without guardian present after initial evaluation.

Signature of Guardian: _____ **Guardian Name:**_____

Pts > 65 years old:
Pnemonia Vaccine: Y / N
Designated Health Care Proxy: Y / N **Name:** _____ **Phone:** _____
Living Will: Y / N
If Yes: Which statement(s) best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

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Assignment and Release

***** I hereby authorize Medicare and/or other insurance benefits to be paid directly to the ***Dermatology and Laser Center of Oklahoma***. ***** I hereby authorize the release of any medical information needed to process my claim(s). ***** I understand that I am personally responsible for any **non-covered** services rendered. ***** I authorize having my picture taken for any necessary medical records. If I am **10 minutes late** for my appointment I will be asked to reschedule. I understand there is a 24 hour cancellation policy on all visits and procedures and that a fee may be applied if not within 24 hours. I also understand that all procedures considered cosmetic or non/covered by insurance will **NOT BE FILED** to my insurance.

Signature_____Date_____

Name *(please print)*: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I accept full financial responsibility for medical expenses incurred at the DERMATOLOGY AND LASER CENTER OF OKLAHOMA:
I understand that my insurance plan is a contract between myself and the insurance provider. Dermatology and Laser Center of Oklahoma does not have control over the benefits and they are not held responsible for what the insurance company **DOES NOT cover**. I understand that my insurance will be filed by this office and that what is not covered will be forwarded to me in the form of a statement of services and that I am responsible for paying the balance.

I understand that I am responsible for:

*I am responsible for providing up to date insurance information within one weeks of my visit and if I DO NOT provide this information I will be responsible for ALL FEES if the insurance denies payment due to "untimely filing".
*All services provided that are **NOT covered** by my insurance plan.
*I understand that my co-pay or coinsurance is due at the time of my procedure.
*I understand that any cosmetic procedures performed in this office are to be paid at the time of service as they are NOT covered by insurance and will not be filed to insurance.
*I understand that I will be legally responsible for all collection cost and attorney fees involving the collection of my account if I default on this agreement.
*I understand that **any unpaid "returned checks"** will be turned over to the District Attorney and handled by their office. A **$50.00** fee will also be added to my charges.
*I understand that I will be charged **$50.00 for all no showed or cancellation less than 48hours**.
To the best of my knowledge, I have provided the most current insurance information available to be used in the filing and collecting of benefits owed to the Dermatology and Laser Center of Oklahoma. I understand that it is my responsibility to provide or know my insurance benefit information at the time services are rendered and accept full responsibility if I do not. I have read and understand the Financial Agreement

Signature: _____ **Date:** _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dermatology and Laser Center of Oklahoma to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO/Third Party Organization/insurance company).

(Dermatology and Laser Center of Oklahoma's Notice of Privacy Practices provides 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. The notice privacy practice states that Dermatology & Laser Center of OK will protect your rights by not allowing any information released from our office if not pertaining to the continuation of care, claims information and/or directed by consent from you.
Dermatology and Laser Center of Oklahoma reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology and Laser Center of Oklahoma Privacy Officer at 9306 South Toledo Court, Suite 100, Tulsa, OK 74137
With this consent, Dermatology and Laser Center of Oklahoma may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO(Third Party Organization/Insurance company), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
With this consent, Dermatology and Laser Center of Oklahoma may mail to my home or other alternative location any items that assist the practice in carrying out TPO(Third party organization/insurance company), such as appointment reminder cards, patient statement, information pertaining to your care.
With this consent, Dermatology and Laser Center of Oklahoma may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, etc**. I have the right to request that Dermatology and Laser Center of Oklahoma restrict how it uses or discloses my PHI to carry out TPO.**
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 Dermatology and Laser Center of Oklahoma's use and disclosure of my PHI to carry out TPO (third party organization such as; insurance carriers).
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dermatology and Laser Center of Oklahoma, may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian **Print Name of Patient or Legal Guardian**

_____ _____
Patient's Name **Date**

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MEDICAL HISTORY

NAME:_____ DOB: _____

PAST MEDICAL HISTORY:

Condition	Date

PAST SURGERIES:

Condition	Date

SKIN DISEASE HISTORY: Please check any that **you** have had or currently have:

- ❑ Acne
- ❑ Actinic keratoses
- ❑ Basal cell carcinoma
- ❑ Squamous cell carcinoma
- ❑ Melanoma
- ❑ Other: _____

FAMILY HISTORY OF SKIN CANCER: Please check any that **family members** have had or currently have:

- ❑ Basal Cell Carcinoma
- ❑ Actinic keratoses
- ❑ Squamous cell carcinoma
- ❑ Melanoma

Which family member?: _____

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MEDICATIONS: (if you brought a LIST, please give it to assistant and SKIP this section)

Medication	Dosage	Frequency	Reason Prescribed

ALLERGIES:

Drug Allergy	Type of Reaction

SMOKING HISTORY:

Do you smoke? Yes____ No____

Former smoker? Yes____ No____

IMMUNIZATIONS: within the last year, have you received:

- If you are over 65, Pneumonia Vaccine: Yes____ No____ If so, when?_____

REVIEW OF SYSTEMS:

Artificial Heart Valve	❑ Yes	❑ No
Pacemaker/Defibrillator	❑ Yes	❑ No
History of Cold Sores	❑ Yes	❑ No
Bleeding Tendency	❑ Yes	❑ No
Allergy to Lidocaine	❑ Yes	❑ No
Allergy to Adhesive	❑ Yes	❑ No
Taking any blood thinners	❑ Yes	❑ No

PleaseList:_____

History of Infectious Disease (Hepatitis B, Hepatitis C, HIV)	❑ Yes	❑ No
Pregnant/Nursing:	❑ Yes	❑ No

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