

Frequently Asked Questions about an Excision Surgery

1. Will it hurt?

When we start the procedure, you will be given local anesthesia with a very small needle. Although everyone's tolerance for pain is different, patients who undergo an excision surgery find the procedure remarkably painless. We pride ourselves on being particularly gentle. When you go home, you will be given a prescription for a pain medication. Most patients report that they did not need it.

2. Will there be a scar?

Yes. It is impossible to undergo surgery without having a scar. Nevertheless, it is our commitment that you will be completely satisfied with the cosmetic outcome. This means that, in some instances, it may take post-operative corrective procedures to attain the desired goal. We are committed to seeing you through that process.

3. What will the scar look like?

Everybody heals at a different rate and the scar will look different over time. Initially, it will be red and bumpy, but eventually, the scar will be a barely visible "hair-thin" white line. We typically camouflage the scar in the lines of facial expression or in your natural skin folds.

4. Will I need plastic surgery?

We perform the reconstructive surgery on site. Once your cancer has been successfully removed, our doctor's expertise lies in the reconstructive component of the surgery. If the cancer involves the inside of the eye, or if the reconstruction requires you to be put to sleep, our doctor will work closely with other specialists with whom we will coordinate your care.

5. Can I go back to work after the procedure?

We recommend that you go home and take it easy. Although the surgery takes place in an ambulatory setting with the use of local anesthesia, we have found that patients often feel "drained" after the procedure. Furthermore, any activity that puts strain on the surgical site or causes your blood pressure to elevate is contraindicated and could compromise the healing process.

6. When can I exercise?

The resting period that we recommend after your surgery depends on where your surgery is located. Typically, we recommend that you do not exert yourself for one week if your surgery is on your head or neck area. This restriction is increased to two weeks when your surgery is on the trunk or extremities. Our doctor may recommend even longer restrictions for certain types of exercise. Make sure you ask us about the specific exercise you intend on doing.

7. Will my insurance cover this procedure?

Generally, yes, as this is a medically necessary procedure. Please contact your insurance carrier for more information.

8. Can I drive home?

Unless you have had surgery near the eye or on your hands, it is reasonable to expect that you can safely drive home. Of course, it is always comforting to have someone give you a ride.

9. Can you do multiple surgeries at the same time?

We do not perform multiple surgeries on the same day. In general, the chances of getting an infection increase when multiple surgeries are done at the same time.

10. Do I need to stop my medications?

In general, we do not recommend that you stop any medications that were prescribed by a doctor without checking with that doctor first. Over the counter medications containing aspirin, ibuprofen, or vitamins should be discontinued if possible.

11. Can I eat before the surgery?

We recommend that you have a light meal before your surgery, as you may be with us for up to an hour or two. And, although we can provide you with crackers and juices; we want you to be as comfortable as possible. You may even want to bring a light snack with you, which you may eat in the waiting room.

12. Will I be put to sleep?

No. All of our surgeries are done under local anesthesia, which is one reason why our procedures are so safe.

13. Can someone be in the surgery room with me?

Although we want you to feel as secure as possible while undergoing surgery, we reserve the right to determine who can be in the surgical suite based on our need for space or the complexity of the case.

14. How long will it take?

It is all dependent on the size and the site of your surgery. It is very difficult to determine how long you will be with us until we have seen you. On average excision procedures last approximately 45 min to an hour.

15. Will I have sutures? Will I have to come back and have the sutures removed?

You can expect to have sutures under a pressure bandage when you leave us. We typically use two layers of sutures, both of which dissolve. This means that you do not need to come back for your stitches to be removed, but you will have a follow up appointment with the doctor to make sure you are healing well. In some cases, we cannot use dissolvable sutures and you would have to come back one to two weeks after the procedure to get them removed.



Katarina G. Chiller, MD

3525 Piedmont Road NE Building 6, Suite 220 Atlanta, GA 30305
 3400 Old Milton Parkway Building C, Suite 555 Alpharetta, GA 30005
 Phone: (404) 446-3200 Fax: (404) 446-3201

Patient Information	
Today's Date: _____	Is this your legal name? Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient's Last Name: _____	If no, what is your legal name? _____
First Name: _____	Former name: _____
Middle Name: _____	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>
Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/>	Widowed <input type="checkbox"/> Single <input type="checkbox"/>
Date of Birth (mm/dd/yyyy): _____ Age: _____	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street Address: _____	Race: _____ Ethnicity: _____
City: _____ State: _____ Zip: _____	Preferred Language: _____
Home Phone #: _____	Social Security Number: _____
Cell Phone #: _____	Occupation: _____
Best # to Reach You: _____	Employer: _____
Other Family Members seen here: _____	Work Phone #: _____
Referring Physician: _____	Referred by: Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/>
In Case of an Emergency	
Name of local friend/family member (not at same address): _____	
Relationship: _____	Home phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Skin Cancer Specialists Center or my insurance company to release any information required to process my claims.

Patient Signature: _____ **Date:** _____

PAYMENT OF FEES

Full payment is expected at the time of service. If we accept your insurance, you must pay your co-pay, deductible and/or co-insurance, and pay in full for any non-covered or denied services. Receipt of services shall constitute your acceptance of this financial obligation. We accept MasterCard, Visa and American Express, as well as personal checks or cash. If your check is returned to us by your bank for any reason, we will charge you the fee allowed by law at that time.

Due to current federal and insurance regulations, any remaining patient balances following claims processing must be paid within 90 days of receipt of your first statement. Overdue accounts will be considered in default of this agreement, and will be transferred to collections for an additional \$25.00 fee. Any further fees accrued through further collections attempts will also be charged to your account.

Sign here to acknowledge that you have read and understand all these terms:

X _____

How will you be paying for your services today? (please check below)

CASH _____ CHECK _____ DEBIT CARD _____ CREDIT CARD _____

INSURANCE INFORMATION

We file claims only if we are contracted with your insurance company or if your insurance company has an out-of-network access agreement with one of our contracted plans. Otherwise, we will provide you with properly coded receipts so you can file yourself. Please be aware that you are ultimately responsible for all fees, regardless of your insurance coverage. You may request a pre-treatment fee estimate, but under Georgia law it is not our responsibility to determine your insurance coverage or to explain your benefits to you. **We are not Medicaid providers.**

PRIMARY INSURANCE: _____ TYPE OF PLAN (HMO, PPO, etc.)

SUBSCRIBER'S NAME: _____ RELATION TO YOU: _____ BIRTHDATE:

ID# _____ GROUP# _____ GROUP NAME:

SECONDARY INSURANCE: _____ TYPE OF PLAN

(if applicable)
SUBSCRIBER'S NAME: _____ RELATION TO YOU: _____ BIRTHDATE:

ID# _____ GROUP# _____ GROUP NAME:

LABORATORY TESTING

All specimens taken here are sent to Finan Templeton Dermatopathology Associates. If your insurance requires you to use any other lab, please check here _____ and notify the receptionist.

ACKNOWLEDGEMENT OF RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I assign to Atlanta Skin Cancer Specialists all payments for medical services they render to me. I understand that services are provided in good faith and I agree to be fully responsible for any services denied by my insurance, including services denied as not medically necessary. This shall serve as my informed consent. I certify that this coverage is in effect now, and I agree to inform this office in writing of any changes.

Authorized Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We keep the health and financial information of our current and former patients private as required by law, accreditation standards, and our policies and procedures. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment

For Health Care Operations

For Treatment Activities

To You: We must give you access to your own PHI.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your referring doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that

need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Also, where required by law, our partners and vendors must protect the privacy of data we may share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

You may request additional information about the Privacy Rule or file a complaint by contacting the Practice HIPAA Policy Officer:

Practice Administrator

3525 Piedmont Road

Bldg. 6, Ste. 220

Atlanta, GA 30305

Office: 404-446-3200

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. We are required by law to follow the privacy notice that is in effect at this time.

Patient Consent for Use and Disclosure of Protected Health Information

This consent outlines how medical information about you may be used and disclosed based on the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). Please review it carefully.

With my consent, Atlanta Skin Cancer Specialists, PC (ASCS) may use and disclose **protected health information (PHI)** about me to carry out **Treatment, Payment and healthcare Operations (TPO)**. Please refer to our Notice of Privacy Practices for a complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ASCS reserve the right to revise their Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator, 3525 Piedmont Road, Building 6, Suite 220, Atlanta, GA 30305.

With my consent, ASCS may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ASCS may mail and/or e-mail to my home or other designated location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

I have the right to request that ASCS restrict how they use or disclose my PHI to carry out **TPO**. However, they are not required to agree to my requested restrictions, but if they do, it is bound by this agreement.

By signing this form, I am consenting to the use and disclosure of my PHI to carry out **TPO**. I am also giving my consent to use photographs for teaching purposes.

I may revoke my consent in writing except to the extent that disclosure has already been made in reliance upon my prior consent. If I do not sign this consent, ASCS may decline to provide treatment to me.

Patient Signature (Guardian/Power of Attorney)

Date

Directions to our Convenient **Alpharetta** Location

Please note: Atlanta Skin Cancer Specialists, PC offers TWO convenient locations to better serve you:

1) **Alpharetta** in the Northside Medical Complex off Old Milton Pkwy

2) **Buckhead** in Piedmont Center off GA 400

Please double-check your paperwork to make sure you know where your appointment is scheduled, or feel free to call us at (404) 446 -3200 and we will be glad to confirm the location for you.

ALPHARETTA OFFICE

Monday & Wednesday Appointments

Northside Medical Complex

3400 Old Milton Parkway
Building C, Suite 555
Alpharetta, GA 30005

Office Hours: 7:30 AM - 3:30 PM

Directions from GA 400:

Located minutes off of 400

Traveling North on 400 – as if coming from downtown Atlanta

- Take **Exit 10** and turn **RIGHT** onto Old Milton Parkway
- Take the first **LEFT** onto Morris Road (at traffic light)
- Take the next **RIGHT** onto Preston Ridge
- Enter the Northside Medical Complex on your **RIGHT**
- We are located in Building C, Suite 555 – **Free Parking**

Traveling South on 400 – as if coming from the Cumming area

- Take **Exit 10** and turn **LEFT** Old Milton Parkway
- NEXT... Take the first **LEFT** onto Morris Road (at traffic light)
- Take the next **RIGHT** onto Preston Ridge
- Enter the Northside Medical Complex on your **RIGHT**
- We are located in Building C, Suite 555 – **Free Parking**

Please contact our office at (404) 446-3200 or visit our website at www.atlantaskincancerspecialists.com for directions to our Buckhead location.