Atlanta Skin Cancer Specialists, PC

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MOHS SURGERY PRE-OPERATIVE INSTRUCTIONS

1. Please eat breakfast / lunch prior to your appointment.

2. Be aware that your surgery can last anywhere from 3-5 hours. Please bring a book/electronic device and a charger to occupy yourself while you are in the office.

3. You may take your regular medication on the day of surgery.

4. You must bring a list of your medications and allergies with you.

5. Please continue ALL your prescribed medications, even blood thinners. If you have a bleeding disorder, call our office to let us know. Stop any non-prescription blood thinners: Aspirin, NDAID, Ibuprofen.

6. In general, antibiotic prophylaxis is NOT indicated for skin surgery, even if you have artificial joints or valves.

7. Notify our office if the site that will be operated on is growing or changing rapidly.

8. Notify our office if you require special accommodations such as wheelchair/mobility assistance.

9. After your surgery you may be scheduled to return to the office for a follow-up. Typically, you will be asked not to plan ***extended*** vacations immediately following surgery. You ***may*** need to be available 7-10 days after your surgery for a suture removal visit. You will also need to refrain from heavy lifting and strenuous activities after surgery for optimal healing of the surgery site. If this is not feasible, please call our office immediately to reschedule your appointment.

10. You **MUST** take a photo of your surgical site on your cell phone or other mobile camera and bring it with you or return to your general dermatologist so that they can identify the site for you and take a picture. Please note that a photo is mandatory for surgery sites.

11. Please arrive at your appointment time or we may need to reschedule you.

We require <u>48 HOURS NOTICE</u> to cancel / reschedule a surgery. Other patients need to be accommodated and we appreciate the opportunity to adjust our schedule accordingly. You will be charged a $500.00 cancellation fee if you cancel your appointment within 48 hours of your scheduled time.

For any scheduled surgery appointments that are missed without notification, there will be a $500.00 no show fee.

When you receive your statement from this procedure, there will be an invoice for the doctor's fee, an invoice for the surgery center, and you may receive a separate bill from the pathology laboratory if biopsies are obtained.

Frequently Asked Questions about Mohs Micrographic Surgery

1. **Why is there a wait?**
   This is a surgery. Please be prepared to wait while we meticulously review your slides.
2. **How long will the Mohs Surgery take?**
   It is all dependent on the size and site of your cancer. It is impossible to determine how long you will be with us until we have seen you. Even then, the full involvement cannot be determined until Dr. Nalovic is able to examine your tissue under the microscope. Because of these uncertainties, we ask you to plan to be with us for at least 3 hours, although it may take less or more time.
3. **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 Mohs surgery find the procedure remarkably painless. We pride ourselves on being particularly gentle. You will be advised on the day of your procedure what can be taken for any discomfort you may experience.
4. **Will I have stitches/sutures? Will I have to come back and have the stitches removed?**
   You can expect to have stitches 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 may 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 will have to come back one to three weeks after the procedure to have them removed.
5. **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 extra post-operative corrective procedures to attain the desired goal. We are committed to that process.
6. **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.
7. **How many stitches/sutures will I have?**
   The number of stitches that you need is determined by the type of closure that Dr. Nalovic performs, the location on your body, the size of the wound, and the size of the suture material. Certain areas are under more tension and require more stitches to ensure the best cosmetic outcome, while other areas have less tension and therefore require fewer stitches. We use the smallest stitches possible to improve cosmetic results and shorten the time it takes to heal; that means that the number of stitches may be higher than if we used larger thread.
8. **Will I need plastic surgery?**
   Dr. Nalovic performs the reconstructive surgery on site. Once your cancer has been successfully removed, Dr. Nalovic's expertise lies in the reconstructive component of the surgery. If the cancer involves the eyelid margin, or if the reconstruction requires you to be put to sleep, Dr. Nalovic works closely with other specialists with whom we will coordinate your care.
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. **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.

11. **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 and/or the complexity of the case.
12. **Will my insurance cover this procedure?**
    This is a medically necessary procedure. The cost will depend on your individual insurance benefits and coverage. As a courtesy to you, we will contact your insurance company 48 hours prior to your surgery to determine your most updated benefits for your specific insurance plan. You will be updated at that time with the results of your insurance verification.
13. **Can I drive home?**
    Unless you have had surgery near the eye, hands, or foot, it is reasonable to expect that you can safely drive home. Of course, it is always comforting to have someone give you a ride.
14. **Do I need to stop my medications?**
    Do not stop any medications that were prescribed by a doctor without checking with that doctor. Self-prescribed over the counter medications containing aspirin, ibuprofen, or vitamin E should be discontinued if possible.
15. **Can I eat before the surgery?**
    We recommend that you have a light meal before your surgery. You may be with us for several hours and although we can provide you with water, we want you to be as comfortable as possible. You may even want to bring a light snack with you.
16. **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" or very tired after the procedure. Furthermore, any activity that puts strain on your surgical site or causes your blood pressure to elevate is contraindicated and could compromise the way you heal.
17. **When can I exercise?**
    The resting period that we recommend after your surgery depends on where your surgery site is located. Typically, we recommend that you do not exert yourself for one week if your surgery site is on your head or neck area. This restriction is increased to two weeks when your surgery site is on the trunk and extremities. Dr. Nalovic may recommend even longer restrictions for certain types of exercise. Make sure you ask us about the specific exercise you intend on doing.
18. **Do I need to have the doctor look at the site before I have surgery?**
    Yes. Dr. Nalovic will examine the site and determine whether Mohs surgery is the right treatment for you before you undergo surgery. Because some of our patients are quite elderly or live far away, we often schedule your consultation visit on the same day as the procedure.
19. **Will I have a follow-up appointment with the physician?**
    Your follow-up status will be determined by the Dr. Nalovic at the time your procedure is complete. If you do not receive a follow up appointment and we do not hear from you with post-operative concerns following your surgery, you will be given a follow-up phone call by our office approximately 8-weeks after surgery to evaluate your progress. Of course, you may call our office at any time with any questions or concerns and we will see you that same day. This is what we call our "Open Door Policy"- Please do call us first as we want to make sure we have a room for you.
20. **If I only have one stage of Mohs, was there really cancer there?**
    Yes. The pathologist who looked at your biopsy saw cancer cells that were not completely removed by the biopsy which is why your dermatologist recommended the Mohs procedure to ensure complete removal of the remaining cancer cells. During the Mohs procedure, Dr. Nalovic examines the skin/tissue under a microscope in order to see if the borders or outside edges of the skin that she removed are cancer-free (we call that "clear margins"). If we see that the edges are cancer-free after the first stage, we know that Dr. Nalovic was able to remove all of the remaining cancer cells in the first try and there is no need to take any more skin from the area.

21. **What causes skin cancer?**
    People have skin cancer for multiple reasons. The two main reasons are sun exposure and genetics. Damaging sun exposure likely took place before you were 18 years old. Although it is very important that you protect yourself now from the sun so that you do not continue to get skin cancers, your current skin cancer is most likely due to excessive sun exposure from your youth. Also, your genetic background determines how likely you are to be affected by sun damage. If you have light colored eyes, blond or red hair, and fair skin, you are more likely to have skin cancer. If you or any of your family members have had skin cancer, you are also at higher risks of developing skin cancer. For more information, please visit www.aad.org or www.skincancerfoundation.org.

22. **What if I did not have this treated?**
    If you have been diagnosed with a skin cancer, it is important that you understand what would happen if this tumor was left untreated. There are three types of skin cancers that we deal with most commonly: Basal Cell Carcinoma, Squamous Cell Carcinoma and Melanoma. An untreated Basal Cell Carcinoma is a cancer that would continue to grow at a relatively slow rate. Even if it seems to you that the biopsy took it all away, it has little extensions under the skin that can continue to grow. Eventually, it could become larger, bleed and be painful and/or disfiguring. In rare cases, it could grow down a nerve and lead to complications including death. Basal Cell Carcinomas do not spread to other parts of the body (metastasize). However, unlike a Basal Cell Carcinoma, an untreated Squamous Cell Carcinoma can metastasize. The same holds true for a Melanoma; and it can do so quite rapidly.

23. **Can I die from this?**
    Squamous Cell Carcinomas and Melanomas can spread to other parts of the body and lead to death under certain circumstances when the area is not treated in a timely manner. It is very rare to die from a Basal Cell Carcinoma. Again, the concern with Basal Cell Carcinoma is that it can be disfiguring and lead to loss of function of nearby anatomical structures.

24. **Can I postpone the surgery*?**
    We do not recommend doing so. Your doctor has sent you here for us to remove your cancer and it should be addressed as soon as possible. It is important that you keep your appointment and not reschedule, so as not to delay your treatment. Delaying surgery could allow your cancer to grow larger, making the reconstruction and your recovery more complicated. In the case of Squamous Cell Carcinomas and Melanoma, it may even lead to the spreading of the cancer to other parts of the body.
    ***Please note: We require 48-hours notice when cancelling/rescheduling a surgery. Surgeries cancelled with less than 48-hours notice may incur a $500.00 cancellation fee.**

25. **Anything else?**
    We recommend a shower the evening or morning before surgery and do not apply make-up, creams, shaving lotion, etc. to the affected area. We also recommend freshly laundered loose fitting clothes to help reduce the chance of you getting an infection. Wear a shirt or blouse that buttons up the front. Please be aware that clothing may get stained during your procedure. You may also want to bring a jacket or sweater, as our office tends to be a little cool. You will be here for several hours on the day of surgery, so bring a good book, iPad and charger, or something to occupy yourself.

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Patient Information	
Today's Date:_____	Is this your legal name? Yes ❑ No ❑
Patient's Last Name:_____	If no, what is your legal name? _____
First Name:_____Middle Name Initial:_____	Former name: _____
Preferred Name: _____	Married ❑ Divorced ❑ Separated ❑
Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑	Widowed ❑ Single ❑ Partner❑
Date of Birth (mm/dd/yyyy):_____Age:_____	Sex: M ❑ F ❑
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: _____	Referred by: Doctor ❑ Family ❑ Friend ❑ Other ❑
Patient E-mail Address:_____	Referring Physician:_____

Primary Insurance:_____Type of Plan (PPO, HMO, POS): _____

Subscriber's Name:_____Relation to Patient:_____DOB:_____

Member ID:_____Group #:_____Group Name: _____

Secondary Insurance:_____Type of Plan (PPO, HMO, POS): _____

Subscriber's Name:_____Relation to Patient:_____DOB:_____

Member ID:_____Group #:_____Group Name: _____

In Case of an Emergency	
Name of local friend/family member:	
Relationship:	Phone #:

Medications and Supplements **Patient Name:**_____

Please list any prescription medications and over-the-counter medications you are currently taking including aspirin, vitamins, and supplements.

Medication	Dose	Frequency	Route	Reason for Taking

Are you allergic to any medications?	Yes ☐	No ☐	If yes, please list below

Notice of Patient Rights & Responsibilities

1. Alpharetta Mohs Surgical Center, LLC (THE FACILITY) recognizes and respects human rights. No patient of THE FACILITY shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State, or the Constitution of the United States. Individuals shall be accorded impartial access to care regardless of race, creed, sex, national origin, language or disability.
2. THE FACILITY will provide patients verbal and written notice of their Rights & Responsibilities prior to the start of the procedure in a manner that is straightforward and easy to understand. Patients who do not speak English will have access to an interpreter.
    i In order to comply with the Department of Health and Human Services' guidelines regarding Limited English Proficient (LEP) persons, THE FACILITY will take the steps necessary to ensure patient understanding.
3. THE FACILITY will accommodate the needs of disabled patients, visitors, and staff to comply with the Americans with Disabilities Act (ADA). In the event that a patient needs his or her service dog present, the service dog will be permitted into the facility with the exception of the operating rooms and the "clean and dirty rooms" of the facility. All service dogs must wear the proper vest to identify the canine as a service dog.
4. It is the policy of THE FACILITY that its patients and/or their representatives may exercise their rights without fear of reprisal.
5. THE FACILITY prides itself on restoring human dignity by treating all patients with respect and politeness. We feel privileged to have been chosen to participate in our patient's care.
6. THE FACILITY respects patient's right to privacy in his/her medical and personal care program. Patient records, care discussions, consultation, examination and treatments shall be held in strict confidence and shall be conducted discreetly. These are only released upon the patient's written request or as required by law.
7. THE FACILITY and all its providers instruct its patients on their condition, prognosis, therapeutic options and preventive measures to the degree these are known and understood by the medical community. Patients have the right to be fully informed about a treatment or procedure and the expected outcome before it is performed
8. Patients have the right to fully understand and agree to their treatment. Therefore, patients must provide written consent for any/all procedures performed at THE FACILITY. If the patient is unable to give consent, the patient must be accompanied by, and THE FACILITY must get verbal or written authorization from, the power of attorney prior to being admitted to THE FACILITY.
9. THE FACILITY will also provide, upon request, information regarding the company, its providers and its services.
10. THE FACILITY will request patients participate actively in treatment decisions. To the extent permitted by law, this includes the right to refuse treatment and the right to change his/her provider if other qualified providers are available. The patient's refusal of treatment will free THE FACILITY from obligation to provide treatment.
11. The patient has the right to choose their own pharmacy.
12. The patient has the right to know that in the event of an emergency it may be necessary to transfer their care to another qualified provider, whether or not such a provider is an employee of THE FACILITY.
13. THE FACILITY will provide patients, upon request, an itemized copy of his/her bill, along with payment policies. Upon request, patients will also be provided a list of services provided and associated fees.
14. THE FACILITY has policies and procedures in place to assure marketing and advertising is not misleading. Patients of THE FACILITY have the right to be protected from false and/or misleading marketing and advertising
15. Patients of THE FACILITY have the right to refuse to participate in experimental research.
16. Patients of THE FACILITY have the right to treatment in a facility that is both physically and emotionally safe which include being free of all forms of abuse or harassment.
    i To promote physical safety for patients and staff alike, all patients and visitors will be required to be accompanied by staff whenever outside of the common waiting area.
    ii In order to protect privacy and to minimize risk of infection only the patient is allowed in the ASC operating room

17. Patients are informed prior to their appointment that THE FACILITY, as a facility-wide policy, and in good conscience, does not honor Advanced Directives. THE FACILITY is afforded this right by the Georgia Department of Human Services, and in compliance with Georgia State and Federal law. THE FACILITY will attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration or if the patient is otherwise incapacitated, regardless of if the patient does or does not have an Advance Directive in place.
18. THE FACILITY is committed to providing excellent surgical care in a setting of warmth and compassion. Should we fall short of our mission, we encourage patients to bring it to our attention. Patients, clients, families or visitors have the right to express complaints regarding any aspect of their care or experience with THE FACILITY without fear of reprisal.

    Grievances and Complaints should be directed to the Practice Administrator either in person or by mail:

    AMSC Practice Administrator
    3330 Preston Ridge Rd.
    Suite 280
    Alpharetta, GA 30005

    Grievances should also be directed to:

    Department of Community Health
    Healthcare Facility Regulation Division
    2 Peachtree Street NW, Suite 31-144
    Atlanta, Georgia 30303
    https://dch.georgia.gov/hfr-file-complaint
    1-800-878-6442

    Patients who are Medicare Beneficiaries may also contact the Office of the Medicare Beneficiaries Ombudsman via the CMS website at:

    http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Responsibilities:

1. THE FACILITY expects patients to provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
2. THE FACILITY requires patients to make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
3. THE FACILITY expects patients to follow the treatment plan established by the physician, including the instructions of nurses and other health care professionals as they carry out the physician's orders.
4. THE FACILITY requires patients acknowledge THE FACILITY's Policy on Advance Directives.
5. THE FACILITY expects patients to promptly accept financial responsibility for any charges not covered by his/her insurance at the time of service.
6. THE FACILITY expects that its property, staff and other patients and their family be treated courteously and with respect. Patients must adhere to these responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

In accordance with Federal ASC Regulations (42 C.F.R. 416.50 (a) (ii)), the following ownership disclosure is made in advance of the procedure.

Alpharetta Mohs Surgical Center, LLC (THE FACILITY) is owned by Katarina G. Lequeux-Nalovic, MD. The physician/owner, Dr. Katarina G. Lequeux-Nalovic, will be performing your procedure. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Alpharetta Mohs Surgical Center, LLC.

ADVANCE DIRECTIVES

In order to be in compliance with the Patient **Self-Determination Act** (PSDA), Georgia state law, and rules regarding advance directives, THE FACILITY requires each patient, **prior to scheduled procedures**, to read and acknowledge THE FACILITY's position on advance directives.

Advance Directives are statements that indicate the type of medical treatment wanted/not wanted in the event that an individual is unable to make those determinations themselves, and who is authorized to make those decisions on their behalf. Advance directives are created and witnessed prior to serious illness or injury. There are many types of advance directives, but two of the most common forms are:

Living Wills. These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions

Durable Power of Attorney for Health Care. This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decision for that individual if he/she should become unable to make his/her own decisions.

As a facility-wide policy, and in good conscience, THIS FACILITY does not honor Advanced Directives. THE FACILITY is afforded this right by the Georgia Department of Human Services, and in compliance with Georgia State and Federal law. THE FACILITY will attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration or if the patient is otherwise incapacitated, regardless of if the patient does or does not have an Advance Directive in place.

Any previously formulated advance directives will not be honored at THE FACILITY. If for any reason you disagree with this policy, please discuss your concerns with your physician before arriving for your scheduled procedure.

FINANCIAL POLICY

This is an agreement between Atlanta Skin Cancer Specialists, PC and/or Alpharetta Mohs Surgical Center, as creditors, and the Patient/Debtor named on this form. In this policy the words “you”, “your” and “yours” mean the Patient / Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Atlanta Skin Cancer Specialists, PC and/or Alpharetta Mohs Surgical Center.

Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license, photo identification, or government issued identification card and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-payment, deductible and co-insurance. It is your responsibility to pay any deductible, co-pay or any portion of the charge as specified by your plan. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of the charges at each visit.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non- covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges that is not covered by insurance.

Social security number. We need your social security number to appropriately and fully process your claims because of the high financial value associated with your visit. Why should you trust us with that information? We receive more training than your bank on methods to protect your information yet your bank has this information. Why do we receive such rigorous training? Because your health information, which we collect to provide your care, is worth 10 times more on the black web than your social security number. Yet you have trusted us with it. Furthermore, highest level protection of your information has become the center piece of electronic health care storage and is mandatory in the United States. Please ask us to provide you with an outline of all the activities we meticulously perform to safeguard all your information. Finally, Doctor Nalovic has the reputation of being a perfectionist and meticulous in all her tasks. This includes performing surgery on you. Having confidence in her and her staff to leave you with the best experience both from a cure rate and a cosmetic outcome should be mirrored with your trust in her protecting your information. If, despite the information provided above, you do not feel that your social security number is safe with us, we would ask you to pay for your entire claim up front. We will work for you to submit your claim to your insurance company without this information and we will refund you once we get paid by them. Alternatively, we can also forward your record to an alternative physician of your choice.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Payments. You are responsible to pay your balance prior to services being rendered. If we have to send you a statement, the balance on your statement is due and payable upon receipt. Monthly statements will show separately all services performed, the finance charge, if any, and payments or credits applied to your account. Statement will show only charges that have patient portion of the balance. Those charges that have been paid will not appear on the statement.

Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless approved by us in writing. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. After discharge from the practice, our physician will only treat you on an emergency basis. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are for 3 days.

Financial Assistance. If you need financial assistance, we can help you to apply for CareCredit. You also can visit www.Carecredit.com for more information and apply online.

Missed appointments. Our policy is to charge for missed appointments. If you do not show up for an appointment, or cancel with less than 48 business-hours' notice, there will be a missed appointment fee of $500. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Returned checks. There is a fee (currently $35) for any checks returned by the bank. It is our policy to not accept any additional personal checks for future appointments in this situation.

Refunds. Because our policy is to collect payment at the time of service based on the information provided by your insurance company, we may find ourselves in a situation to refund you money once your claim has processed. By signing this agreement, you agree to deposit the refund check within 60 days. If you lose, misplace, or otherwise forget to do so in that time frame, we will be glad to provide you with a replacement check, which you will pick up in person from our office. You will be responsible to pay for the bank cancelation fee and any additional administrative fees of the original refund check. Any refund due to the patient that is under $25, will be refunded through the credit card used on the date of service (when applicable).

Waiver of confidentiality. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your "past due" status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

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, Care Credit, and personal checks. 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. We do **NOT** accept cash payments. There is a 1.5% processing fee when rendering payment with American Express or a 6% administrative fee when rendering payment Care Credit.

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.

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.**

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, Alpharetta Mohs Surgical Center, or my insurance company to release any information required to process my claims.

ACKNOWLEDGEMENT OF RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
I assign to Atlanta Skin Cancer Specialists, and/or Alpharetta Mohs Surgical Center 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.

Damage to hearing Aids and other removable devices. We strongly recommend that hearing aids and any easily removable device worn by the patient be removed during the surgical procedure. ASCS accepts no financial responsibility or liability for loss or damage done to these devices during a surgical procedure if not removed.

Interpretation Services. All fees related to professional interpretation services are your responsibility. These fees may include the reservation of an interpreter, any related cancellation costs, additional fees for mileage accrued for an onsite interpreter, and the hourly cost for the interpretation service itself. We are a small solo practitioner facility and do not have the resources to coordinate interpreter services.

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.

Effective date. Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) 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 and our Business Associates and their subcontractors 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 is information about you, including demographic information, that identifies you and that relates to your past, present or future physical or mental health condition and related health care services.
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.

How we use your PHI:
1. For Payment
2. For Health Care Operations We may use or disclose your PHI, as necessary, to contact you at home or another designated location to remind you of your appointment.
3. For Treatment Activities
4. For You: Release of medical records require written request
5. For 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 in writing, 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.
6. For Compliance with the 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. 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 informed us to stop. You

are allowed to request that we not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

Your Rights
Under federal law, you have the right to:

- Review this notice
- 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 disclosures of your PHI.
- You will be notified of breaches if they occur with your unsecured (PHI that is not protected by encryption or destruction according to HHS regulations) PHI.

How we protect information
We are dedicated to protecting your PHI. We set up a number of policies and procedures 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:
Office for Civil Rights in the U.S. Department of Health and Human Services
Regional Office IV – Atlanta
Regional Manager – Roosevelt Freeman
Sam Nunn Atlanta Federal Center
Suite 16T70
61 Forsyth St SW
Atlanta, GA 30303-8909

The contact person for our Practice from whom an individual may request additional information about the Privacy Rule or file a complaint is the Practice Administrator and HIPAA Policy Officer:

Practice Administrator
3330 Preston Ridge Rd
Suite 280
Alpharetta, GA 30005
Office: 404-446-3200

Signature Page

Patient Name (please print):_____DOB:_____Date:_____

Notice of Patient Rights and Responsibilities / Notification of Ownership (pg. 3-5)
By signing below, you, or your legal representative, acknowledge that the patients' rights and responsibilities and disclosure of ownership has been made in advance of the date of the procedure, and that you have decided to have the procedure performed at Alpharetta Mohs Surgical Center, LLC.

Patient/Guardian Signature_____Date_____

Notification of AD (pg. 5)
I have read and acknowledge that THE FACILITY does not honor Advance Directives.

Patient/Guardian Signature_____Date_____

Financial Policy (pgs. 6-8)
I have read and agree to all the terms and conditions as set forth in the Financial Policy.

Signature:_____Date: _____

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 front desk staff.

HIPAA Notices of Privacy Practices (pg. 9-11)
By signing this form you acknowledge receiving Alpharetta Mohs Surgical Center (AMSC) and Atlanta Skin Cancer Specialists (AS CS) HIPAA Notice of Privacy Practices.

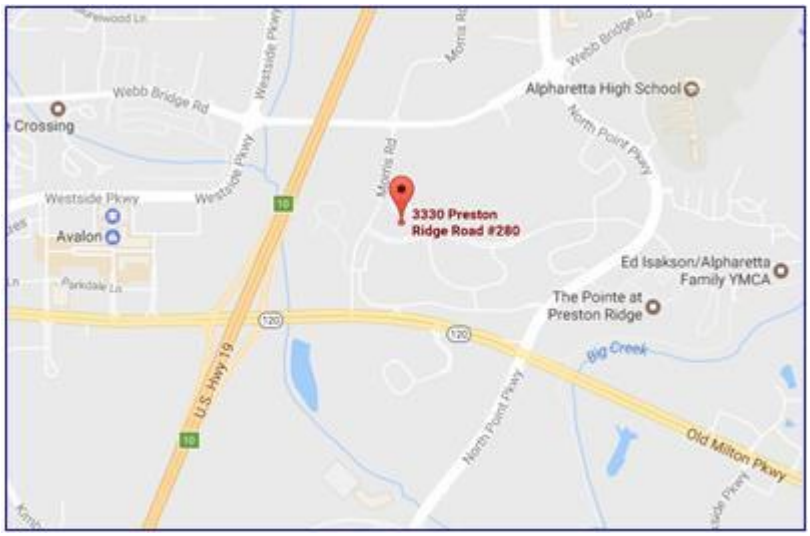
Patient/Guardian Signature:_____Date: _____

Directions to Atlanta Skin Cancer Specialists

Atlanta Skin Cancer Specialists, PC is located in Alpharetta, Georgia and provides free parking

Alpharetta in the Preston Ridge Professional Campus off Preston Ridge Road

Preston Ridge Professional Campus
3330 Preston Ridge Road
Suite 280
Alpharetta, GA 30005
Office Hours:
8:30 AM - 4:30 PM (Monday-Thursday)
7:30 AM – 3:30 PM (Friday)



Directions from GA 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 Preston Ridge Professional Campus on your **LEFT**
- We are located in Suite 280 – **Free Parking**

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

- Take **Exit 10** and turn **LEFT** Old Milton Parkway
- Take the first **LEFT** onto Morris Road (at traffic light)
- Take the next **RIGHT** onto Preston Ridge
- Enter the Preston Ridge Professional Campus on your **LEFT**
- We are located in Suite 280 – **Free Parking**