Cary: (919) 363-7546 Pinehurst: (910) 295-1761

ACMS American College of Mohs Surgery
*Fellowship trained skin cancer and reconstructive surgeons*

CARY SKIN CENTER
*Skin Cancer Center*

Dear Patient,

Thank you for choosing Cary Skin Center for your Mohs Micrographic Surgery. Cary Skin Center is committed to providing you with the highest quality healthcare.

We look forward to seeing you at your appointment. Please review and complete the attached forms and bring them with you to your appointment along with your insurance cards. If you have any questions, please do not hesitate to call our office **Monday, Tuesday and Thursday from 7:30 AM to 5:00 PM and on Wednesday and Friday from 7:30 AM to 1:30 PM** for assistance. Our office phone is **919-363-7546**.

It is recommended that you bring someone with you the day of your procedure. **Please continue any medications that you take on a daily basis, unless otherwise instructed. This includes any physician prescribed aspirin, Coumadin, Warfarin, Plavix and all similar drugs. Bring a detailed list of medications to your appointment. Include the medication name, dosage and frequency taken for all prescribed, over the counter and supplements.** Have a light breakfast/lunch since your appointment may last several hours.

**VISIT POLICIES**

**Surgical patients may be accompanied by ONE visitor, no children. Visitors may remain with you in the procedure room until the doctor starts the procedure. Visitors are welcome to wait in our lobby.**

**NO visitors are permitted for non-surgical appointments. Exceptions will be made for patients that rely on support for their care. Do not bring children or pets to any appointment.**

**Audio Recording, Video Recording, or Photographing Any Patients, Clinic Staff, Providers, Rooms, or Surgeries is PROHIBITED.**

**Cell phones and other electronic devices must be MUTED and SILENCED inside the facility.**

**PREPARE FOR YOUR VISIT**

- **MORNING patients should plan on staying until NOON, AFTERNOON patients should plan on staying until 5PM.**
- **FORM A – PLEASE TAKE A PHOTO AT YOUR EARLIEST CONVENIENCE**
- **FORM B – COCHLEAR IMPLANT - Call «Appointment_Location_Phone» as soon as possible and provide the information if applicable.**
- **COMPLETE FORMS C, D & F AND BRING THEM WITH YOU TO YOUR APPOINTMENT**
- **READ FORM E – INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY – DO NOT SIGN**
- **If you have any questions related to the Financial Policy of Cary Skin Center, please call our Insurance Department at (919) 277-1010.**
- **POWER OF ATTORNEY, ADVANCE DIRECTIVE and DNR: If there is a Medical Power of Attorney, Advance Directive or DNR, a hard copy will need to be presented at the time of the appointment. If the Power of Attorney is in effect, whoever holds the Medical Power of Attorney should be present at your appointment.**
- **For more information and directions to our facility, please see www.caryskincenter.com**

**IF YOU HAVE AN EXISTING CANCER POLICY, IN ADDITION TO YOUR MEDICAL INSURANCE, OR IF YOU WOULD LIKE YOUR RECORDS SENT TO A DOCTOR OTHER THAN WHO REFERRED YOU, PLEASE REQUEST TO FILL OUT A MEDICAL RELEASE OF RECORDS FORM THE DAY OF YOUR APPOINTMENT. TO PROTECT YOUR HEALTH INFORMATION, NO RECORDS WILL BE RELEASED WITHOUT A SIGNED RELEASE FORM. BEGINNING AUGUST 15, 2014, A $15.00 FEE WILL BE ASSESSED FOR CANCER POLICY RECORD REQUESTS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE AT 919-363-7546.**

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**Form A**

# Biopsy Site Location and Submission of Photos

Thank you for choosing Cary Skin Center for your Mohs surgery. It is very important that the biopsy site be identified and photographed prior to surgery in the event that it heals on the surface making it difficult for us to locate. **We ask that you take these photos as close to the biopsy date as possible to ensure visibility**.

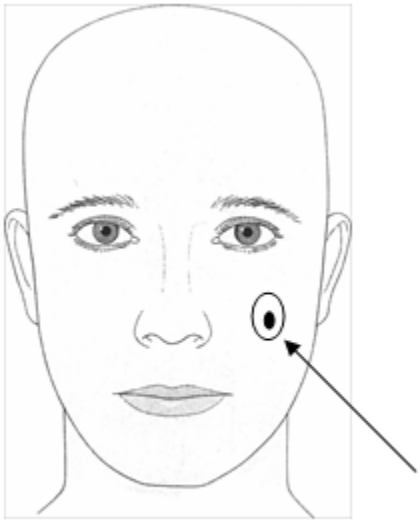
Following are some helpful instructions when taking photos for your upcoming appointment:

**** PLEASE EMAIL PHOTOS AT LEAST 2 BUSINESS DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT ****

1. **Mark the biopsy site by circling it with a washable pen, make-up pen or use computer graphics.**
2. **Take 2 photos: one up-close and one from a distance to identify the location of the lesion.**
3. **Email photo to: photo@caryskincenter.com – choose "Medium" or "Small" for file size.**
4. **INCLUDE YOUR INITIALS AND DATE OF BIRTH, OR INITIALS AND APPOINTMENT DATE, IN THE BODY OF THE EMAIL.** A reply will be sent once the photos are received.

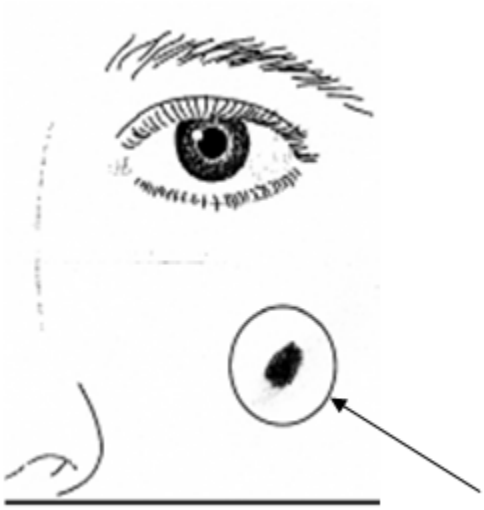
If you find you are unable to take a photo, please call our office as soon as possible at **«Appointment_Location_Phone»** to schedule a no charge photo appointment with a member of our clinical team.

We accept the following types of digital images via email: **jpg, gif, bmp, png, and pdf**.



Example of an ideal distance location photo.

Please circle or point to the biopsy site location.



Example of an up-close location photo.

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**FORM - B**

# ATTENTION!!

## ** PATIENTS THAT HAVE UNDERGONE CHEMOTHERAPY OR A BLOOD / PLATELET TRANSFUSION IN THE PAST 6 MONTHS **

## ** PATIENTS WITH A COCHLEAR IMPLANT **

## **WE MUST SPEAK TO YOU AS SOON AS POSSIBLE.**

## Please call our Clinic Team Line at (919) 277-1017.

Thank you in advance for helping us to give you the best medical care possible!

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# *Medicare Patient Registration* *FORM C*

Name**:** _____

Mailing / Billing Address: _____
Street # Street Name Apt#

_____
City State Zip Code

Social Security #: _____ Date of Birth: _____/_____/_____

Home Phone: (_____)_____Work Phone: (_____)_____ Cell Phone: (_____)_____

Circle the Preferred Phone Number to contact you: H W C Email: _____

If married, Spouse's **Name:_____ Spouse's **Date of Birth: _____/_____/_____
(**This information is **required** if your insurance policy is in your spouse's name)

**Answer questions below by placing a check in the appropriate column:**

| | |
|---|---|
| Have you recently joined a Medicare HMO?<br>If yes, identify: _____ | ☐ Yes ☐ No |
| Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? | ☐ Yes ☐ No |
| Are you covered by a HMO/PPO which makes Medicare secondary?<br>If yes, identify: (see back of this form for options) | ☐ Yes ☐ No |
| Is this illness covered by the VA (Veterans Administration)? | ☐ Yes ☐ No |
| Are you receiving Medicaid? | ☐ Yes ☐ No |

Are you a resident of a Skilled Nursing Facility? ☐ Yes ☐ No or Hospice? ☐ Yes ☐ No

**This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read, print name and sign the following statement:**

✓ **I ,_____ authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.**

_____ _____
**Signature** **Date**

**If you have another policy, we are required to keep a separate signature on file**. Your signature below indicates authorized benefits are made, on your behalf, by the supplemental carrier named below:

**Name of other carrier: _____ ☐ Primary ☐ Secondary Name of Policy Holder** _____

**Social Security # of policy holder: _____ Date of Birth of Policy Holder** _____/_____/_____

**I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.**

_____ _____
**Signature** **Date**

***IMPORTANT INFORMATION FOR NEW PATIENTS***

***Federal Law requires all healthcare practices to obtain, verify and record information that identifies each patient.***

***<u>What this means for you</u>: When you arrive at Cary Skin Center, PA, we will ask to see a photo ID issued by a local, state or federal government agency such as a driver's license, passport or military ID. If you do not have a government issued photo ID, please bring two forms of non-photo ID such as Social Security Card, school or company ID or a utility bill with your name and address visible. Please contact Cary Skin Center, PA prior to your appointment if you do not have available forms of identification. You may reach us at 919-363-7546.***

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# Patient History Form

**Patient Name:** _____ **Patient Date of Birth:** _____

## I. Reasons for Visit

Reasons for your visit? _____ Who is your referring doctor? _____

**Do you have any of the following implants?**

| | Yes | No | Manufacturer | Model/Serial Number | Implant Date | Notes |
|---|---|---|---|---|---|---|
| Pacemaker | | | | | | |
| Defibrillator | | | | | | |
| Cochlear Implant | | | | | | |
| Other | | | | | | |

***Have you undergone chemotherapy or a blood / platelet transfusion in the past 6 months? Yes ☐ No ☐**

***Do you require antibiotics prior to dental or surgical procedures? Yes ☐ No ☐**

## II. Medications

**List any current medications, vitamins and minerals. Please use a separate sheet of paper if necessary.**

| Drug | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ **I currently am not taking any medications, vitamins or minerals.**

## III. Medication Allergies

| Medication Allergy | Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |

| Medication Allergy | Reaction |
|---|---|
| 4. | |
| 5. | |
| 6. | |

☐ **I have no known medication allergies.**

# Patient History Form

**Patient Name:** _____ **Patient Date of Birth:** _____

## IV. Local Pharmacy Information

| | |
|---|---|
| Local Pharmacy Name | |
| Pharmacy Address | |
| Pharmacy Phone Number | |

## V. Past Medical History

**Do You Have a History of Any of the Following?**

| | Yes | Details |
|---|---|---|
| **I HAVE NO PAST MEDICAL PROBLEMS.** | O | |
| Arsenic Exposure **(worked in tobacco fields)** | O | |
| Artificial Joints / Heart Valve | O | |
| Bleeding Disorders/Problems | O | |
| Cancer | O | |
| Cognitive Impairment/Dementia | O | |
| Diabetes | O | |
| Fever Blister/Cold Sores | O | |
| Heart Disease/Cardiac Stents or valves | O | |
| Heart Murmur | O | |
| Hepatitis | O | |
| High Blood Pressure | O | |
| Immune System Problems | O | |
| Lung Disease | O | |
| Lymph Node or Spleen Removal | O | |
| Organ Transplant | O | |
| Other | | |

| | Yes | Details |
|---|---|---|
| Psychiatric Disease | O | |
| Radiation Therapy | O | |
| Rheumatic Fever | O | |
| Seizures | O | |
| Stroke | O | |
| Substance Abuse / Addiction | O | |
| Thyroid Disorder | O | |
| Tuberculosis | O | |

| **SKIN HISTORY** | **Yes** | |
|---|---|---|
| Actinic Keratosis | O | |
| Basal Cell Carcinoma | O | |
| Squamous Cell Carcinoma | O | |
| Dysplastic Nevus (abnormal moles) | O | |
| Melanoma | O | |
| X-ray therapy for any skin condition | O | |
| Do you form thick or raised scarring from a cut or burn? | O | |

**Please List Any Other Past Medical Problems:** _____

_____

_____

# Patient History Form

**Patient Name:** _____ **Patient Date of Birth:** _____

## VI. Past Surgeries and/or Hospitalizations

| Operation | Date | Notes | Anesthesia Problems? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

☐ **I have no past surgeries and/or hospitalizations.**

## VII. Social History

| TOBACCO PRODUCTS | Yes | |
|---|---|---|
| **I Do Not Use ANY Tobacco Products** | o | |
| **I Use Tobacco Products:** | o | Circle amount below as applies to you: |
| - Cigarettes | | EVERY DAY SOME DAYS |
| - Cigars | | EVERY DAY SOME DAYS |
| - Chewing Tobacco | | EVERY DAY SOME DAYS |
| - E-Cigarettes | | EVERY DAY SOME DAYS |

| ADVANCED CARE PLAN & LIVING WILL | Yes | |
|---|---|---|
| **I Do Not have a Care Plan** | o | |
| **I have a Care Plan:** | o | Circle answer below: |
| I have a copy of the plan | | YES NO |
| | | |
| **Name of Proxy** | | |

## VIII. Family History

**Do You Have a Family History of Any of the Following?**

| | Yes | Afflicted Family Member(s) | | Yes | Afflicted Family Member(s) |
|---|---|---|---|---|---|
| *I **do not** have any family medical history of the following illnesses. | o | | Heart Disease | o | |
| *Adopted | o | | High Blood Pressure | o | |
| Abnormal Bleeding/Clotting | o | | Malignant Melanoma | o | |
| Cancer | o | | Other | o | |
| Diabetes | o | | Skin Cancer | o | |

# Patient History Form

**Patient Name:** _____ **Patient Date of Birth:** _____

## IX. Review of Systems

**Have you experienced any of the following symptoms within the last 6-8 weeks?**

| Symptom: | Yes | No |
|---|---|---|
| ALLERGIC/IMMUNOLOGIC | | |
| allergy to lidocaine or numbing medications | o | o |
| CARDIOVASCULAR | | |
| chest pain | o | o |
| abnormal leg swelling | o | o |
| CONSTITUTIONAL SYMPTOMS | | |
| unexpected weight loss or weight gain | o | o |
| DERMATOLOGIC | | |
| new skin growth/bumps | o | o |
| fever blisters/cold sores | o | o |
| GASTROINTESTINAL | | |
| currently pregnant | o | o |
| nausea, vomiting, diarrhea | o | o |

| Symptom: | Yes | No |
|---|---|---|
| GENITOURINARY | | |
| currently breast feeding | o | o |
| kidney problems | o | o |
| HEMATOLOGIC/LYMPHATIC | | |
| enlarged lymph nodes | o | o |
| NEUROLOGICAL | | |
| numbness or tingling | o | o |
| headache | o | o |
| RESPIRATORY | | |
| cough | o | o |
| shortness of breath | o | o |
| PSYCHIATRIC | | |
| anxiety | o | o |

Explain below if you answered yes above: _____

_____

_____

_____

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**FORM - E**

# INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

Patient Name: _____ Patient Date of Birth: _____

This form is designed to provide you with the necessary information that you will need to make an informed decision on whether or not you wish to have Mohs surgery performed. All of the information provided in this form will be or has been reviewed with you by the physician. If you have any questions, please do not hesitate to ask us. Do not sign this form until you are instructed to do so.

## WHAT ARE THE POTENTIAL COMPLICATIONS AND SIDE EFFECTS OF SKIN SURGERY?

1. **PAIN:** Some mild discomfort is experienced when the area is first anesthetized with the numbing medication. You may experience some mild discomfort during the procedure if the numbing medication has worn off in a particular location. This is easily remedied by immediately giving more anesthetic in that area. After the procedure some discomfort will be experienced at the surgical site. This is easily controlled with pain medications for a few days.

2. **INFECTION:** Any time that the skin is injured an infection is possible. The rate of infection is very low. Some patients will receive postoperative antibiotics to prevent an infection. If you feel that your wound is infected after surgery please call our office immediately**.**

3. **BLEEDING:** When you leave our office you will have a pressure bandage applied to your wound. Bleeding is always possible after surgery. Most cases of postoperative bleeding are easily stopped by applying pressure for 20 minutes over the site. If this does not work please call our office immediately.

4. **SWELLING:** After surgery you should expect some swelling where your surgery was performed and around the wound as well.

5. **HEMATOMA:** A hematoma is a collection of blood that forms under the skin. This results from bleeding that occurs after the surgery. A “lump” forms under the skin, which represents the dried blood. If this occurs call our office immediately.

6. **SCAR FORMATION**: Any time that the skin is injured a scar will form. Some scars are more noticeable than others, but a scar is always present. A scar will form after your surgery. Hypertrophic and keloidal scarring are possible. If you have a history of bad scarring please advise us at the time of your visit. The cosmetic appearance following surgery is unpredictable.

7. **WOUND DEHISCENCE:** This means that your wound has broken back open after it has been repaired with sutures. It is very important to take it easy after your surgery so that unnecessary strain is not placed on the wound. This is an uncommon complication.

8. **FAILURE OF FLAP OR SKIN GRAFT:** After your surgery is completed we will need to repair the wound. Some patients are repaired with either a flap or skin graft. A flap is when skin is borrowed from a nearby site to close the defect. A skin graft is when a piece of skin is taken from one site and transplanted to another. A possible complication is the failure of either of these to take at the new site. Smoking is a documented risk for this complication. If you are a smoker it is recommended that you discontinue smoking for one week before and after the procedure.

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**FORM - E**

# INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

9. **TEMPORARY OR PERMANENT NERVE DAMAGE:** The primary goal of your surgery is to completely remove the tumor. In order to accomplish this, it is sometimes necessary to damage a nerve. Nerve damage can be temporary or permanent. Recovery usually takes 6 months or more, and rarely can require additional surgery. Nerve damage may be limited to a loss of sensation or may include paralysis.

10. **DISTORTION/ALTERATION OF SURROUNDING ANATOMIC FEATURES:** The repair or healing of surgical wounds may distort the appearance of adjacent structures. Our goal is to completely remove your skin cancer, and then concern ourselves with the function and appearance of surrounding anatomic structures.

11. **TUMOR RECURRENCE:** No skin cancer treatment has a guaranteed 100% cure rate. However, Mohs surgery has been shown to have the highest cure rate for the treatment of skin cancer.

**The complications of surgery are not limited to the above list.**

I acknowledge that I have read the entire consent form. I understand its contents, and the doctor and/or his associate, has adequately informed me of the risks, benefits, advantages, disadvantages, alternatives, and possible complications of skin surgery. I also understand that the postoperative size of the surgical wound after removing the skin cancer, and the method of repair cannot be predicted in advance, and I could require referral for additional closure or revision of the procedure site.

I further request the administration of such analgesia and/or sedative medication as deemed necessary or desirable for the completion of the procedure. I understand that the administration of medication carries risks separate and apart from the risks of the procedure.

I recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurances have or can be made concerning the results of such treatment. I further acknowledge that there have specifically been no guarantees as to the cosmetic results from the procedure.

All of my questions and concerns have been answered, and I hereby consent to Mohs surgery and repair if necessary to be performed by Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates upon _____ (patient). I have identified and confirmed the location(s) of my surgical site(s).

I also consent to the taking of photographs before, during, and after the procedure. I understand that these photographs are important to document and follow my progress after surgery. These photographs will belong to Cary Skin Center, and may be used for research, educational, and scientific purposes. This may include presentation at lectures or publication in medical journals. In such an event, I will not be identified by name. I expect no compensation for any such use of these photographs, and I waive all my rights to any claims for payment or royalties. I also release Dr. Clark, Dr. Ingraffea, Dr. Eickstaedt, and/or their associates/assistants from any liability in connection with the use of such photographs.

**I understand that the use of digital devices (video camera, camera, tape recorder, cell phone or any other recording device) to record Mohs Micrographic Surgery or any other medical procedure performed by the physicians and staff of the Cary Skin Center is strictly prohibited.**

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**FORM - E**

# INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

I agree that any tissue removed during the course of the operation may be examined, documented, preserved and/or disposed of in a manner considered proper for diagnosis, study, and advancement of medical knowledge.

The tissue obtained in this procedure may be examined by a pathologist at your providers direction. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

I understand that Cary Skin Center has recommended that a spouse, relative, or friend accompany me to Cary Skin Center and drive me home following my surgery. If I decide to drive myself home, I understand and assume the risk involved.

I further consent that in the event of an emergency and I am transferred from Cary Skin Center to another facility I request that any and all documents pertaining to my care at the receiving facility be sent to Cary Skin Center following my treatment at that facility.

My provider has discussed my procedure and all my questions have been answered. I understand the risks and benefits and I agree to the procedure. I have read the above consent form and received a copy.

Date: _____ Time: _____ am/pm

| _____ | _____ | _____ |
|---|---|---|
| Patient's Printed Name or guardian/next of kin | Signature | Relationship, if other than patient. |

Patient's Date of Birth: _____

I confirm that this form has been completely reviewed with the patient. The potential risks, side effects, and complications were all discussed. All of the patient's questions have been answered.

| _____ | _____ | _____ |
|---|---|---|
| Physician's Signature | Witness Signature | Date |

Robert E. Clark, MD, PhD or Adam A. Ingraffea, MD or Joshua B. Eickstaedt, MD

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CARY SKIN CENTER

# Authorization for Release of Information Form F

Name of Patient : _____ Date of Birth _____

Cary Skin Center, P. A. is authorized to release protected health information about the above named patient in the following manner and to identified persons.

| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ☐ **No restrictions apply. Any/All information may be released to all parties named on this form.** | |
| ☐ Voice Mail | ☐ Results of lab tests/x-rays<br>☐ Other_____ |
| ☐ Spouse (provide name and phone number) _____ | ☐ Financial<br>☐ Medical |
| ☐ Other (provide Name and phone number) _____ | ☐ Financial<br>☐ Medical |
| ☐ Parent (provide name and phone number) _____ | ☐ Financial<br>☐ Medical |
| ☐ Email/Marketing communication-Provide email address* _____<br>*In order for email communication to occur, please accept the disclosure below: | ☐ Financial<br>☐ Medical<br>☐ Breach notification |
| ☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication. | |
| **If there is a friend or family member we can contact in the event of an emergency, please print their name below. This information will remain active and in your file until you request in writing that it be changed.** | |
| **Print Name** **Relationship** **Phone** | |

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

**Signature of Patient or Personal Representative**

*Description of Personal Representative's Authority (attach necessary documentation)

_____