Mei Medical Building
6370 SW Borland Rd,
Suite 200
Tualatin, Oregon 97062

Phone: 503.691.1122
Fax: 503.691.1144

www.drdavidkao.com

skin cancer surgery center

You've been diagnosed with skin cancer . . . what next?

You have been referred to the **Skin Cancer Surgery Center** to treat your skin cancer using Mohs Micrographic Surgery. Your surgical reconstruction will also be performed on the same day.

Mohs Micrographic Surgery is the most advanced and effective treatment procedure for skin cancer removal with the highest cure rate. With the Mohs technique, the surgeon is able to see beyond the visible disease, to precisely identify and extract the entire tumor layer by layer while leaving the surrounding healthy tissue intact and unharmed. Our surgeons are highly trained and recognized for excellence in the Mohs technique and specialize in Mohs and reconstructive surgery.

Important information for your surgery

❏ **Please complete and bring with you the enclosed paperwork:**
- ☐ Patient Questionnaire
- ☐ Financial Policy
- ☐ Authorization to discuss

Do you need assistance with (but not limited to) transfers, restroom use, wheelchair use: Yes ❏ No ❏

If yes, you will need to have an escort that can stay with you throughout your procedure. (move to Brochure for what to expect)

❏ You are encouraged to eat breakfast on the day of your surgery.

❏ Please arrange for someone to drive you home after the procedure. If we give you pain or relaxation medication you may not drive yourself home.

❏ Review the list of medications to stop prior to your procedure. It is important to discontinue any aspirin containing medications 2 weeks prior to your procedure.

❏ Please bring photo ID, all health insurance cards and any co-payment and/or deductible payments due.

Do not hesitate to call with any questions or concerns, **(503) 691-1122**.

For additional information regarding your upcoming surgery please visit our website at **www.drdavidkao.com**.

If you should need to cancel or reschedule any appointment, please call the office at least 72 hours in advance for surgery and 24 hours in advance for follow-ups.

Medication instructions for surgery patients

These instructions are to be followed before and after your surgery.

Our goal is to help you identify substances that will increase your tendency to bleed at the time of surgery and during the post-operative period.

Please CONTINUE

taking all PRESCRIBED blood thinning medications such as:

- ❑ Coumadin (Warfarin)
- ❑ Persantine (Dipyridamole)
- ❑ Pradaxa (Dabigatran)
- ❑ Plavix (Clopidogrel)
- ❑ Ticlid (Ticlopidine)
- ❑ Eliquis (apixaban)
- ❑ Aspirin *Continue your Aspirin if you have a history of atrial fibrillation, stents, blood clots, stroke, TIA or if your medical doctor recommends not stopping.*

Please STOP

taking all NON-PRESCRIBED blood thinning medications.

The following is a list of common over-the-counter medications and substances that may increase your tendency to bleed and should be discontinued 2 weeks prior to surgery.

ASPIRIN BASED PRODUCTS (INCLUDING BUT NOT LIMITED TO):

ALKA SELTZER
ANACIN, BUFFERIN
ECOTRIN, EMPIRIN
EXCEDRIN
FLIORINAL
NORGESIC
PERCODAN
ROBAXISAL
TRIGESIC
VANQUISH

ANTI-INFLAMMATORIES (INCLUDING BUT NOT LIMITED TO):

ANAPROX/ALEVE
BRUFEN
DOLOEID
IBUPROFEN
INDOMETHACIN
MIDOL
MOTRIN
TRILISATE
VOLTAREN

SUPPLEMENTS:

FISH OIL/OMEGA 3
GARLIC
GINKGO BILOBA
MULTIVITAMINS
VITAMIN E

How to find us

From the west
Take Highway 26 East

- Exit 69A, Highway 217 toward Tigard/Salem;
- Merge onto Interstate 5 South toward Salem;
- Take exit 289 – Tualatin/ Sherwood exit;
- Turn left onto SW Nyberg Road and continue on Nyberg as it curves to the right and becomes 65th Avenue;
- Drive past the hospital to the first light;
- Turn left onto Borland Road. We are the 3rd driveway on the right across the street from the hospital.

From the east
Interstate 84 West / US-30 West

- Merge onto Interstate 5 South via exit on the LEFT toward Beaverton/Salem;
- Take exit 289 – Tualatin-Sherwood exit;
- Turn left onto SW Nyberg Road and continue on Nyberg as it curves to the right and becomes 65th Avenue;
- Drive past the hospital to the first light;
- Turn left onto Borland Road. We are the 3rd driveway on the right across the street from the hospital.

From the south
Interstate 5 North towards Portland

- Take exit 289 – Tualatin-Sherwood exit;
- Turn right on SW Nyberg Road and continue on Nyberg as it curves to the right and becomes 65th Avenue;
- Drive past the hospital to the first light;
- Turn left onto Borland Road. We are the 3rd driveway on the Right across the street from the hospital.

From the north
Interstate 5 South / Salem

- Take exit 289 – Tualatin-Sherwood exit;
- Turn left onto SW Nyberg Road and continue on Nyberg as it curves to the right and becomes 65th Avenue;
- Drive past the hospital to the first light;
- Turn left onto Borland Road. We are the 3rd driveway on the right across the street from the hospital.

Your destination:

Skin Cancer Surgery Center
6370 SW Borland Road
Dark grey and white "mei" building
2nd floor, Suite 200

PATIENT INTAKE AND MEDICAL HISTORY

Skin Cancer Surgery Center
www.drdavidkao.com

Patient Name_____
(Last) (First) (Middle)

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____ Social Security # _____

Date of Birth _____ Age _____ Male ❑ Female ❑ Marital Status S ❑ M ❑ D ❑ W ❑ DP ❑

Language: ❑ English ❑ French ❑ German ❑ Russian ❑ Spanish ❑ Decline

Emergency Contact _____ Relationship to patient_____

Home Phone _____ Cell Phone _____

Referring Physician _____ Office Phone_____

Primary Care Physician _____ Office Phone_____

Please tell us how you learned of our service or whom we can thank _____

_____

PRIVATE INSURANCE INFORMATION

PRIMARY

Insurance Name_____

Subscriber Name _____ ID # _____

Relationship to Patient _____ DOB _____

SECONDARY

Insurance Name _____

Subscriber Name _____ ID # _____

Relationship to Patient _____ DOB _____

VOICE MAIL AUTHORIZATION

The purpose of this authorization is to provide our patients an opportunity to permit verbal release of Protected Health Information (PHI). By checking Yes, you authorize Skin Cancer Surgery Center, their physicians, physician assistants, medical assistants, administration staff and other personnel to leave detailed messages concerning medical advice, test results, billing and appointment details at the number(s) indicated below.

Authorization: Yes ❑ No ❑ Authorized phone number _____

PHARMACY INFORMATION

Please complete your pharmacy information below as we may be prescribing an antibiotic or other medications as necessary:

Pharmacy Name _____ Location _____

Phone _____

PLEASE BE SURE TO COMPLETE ALL 3 PAGES OF THE APPLICATION

MEDICAL HISTORY

Artificial Heart Valve Yes ❑ No ❑

Atrial Fibrillation Yes ❑ No ❑

Autoimmune Disease Yes ❑ No ❑ Type? _____

Blood Clots Yes ❑ No ❑

Blood Disorders Yes ❑ No ❑ Type? _____

Cancer (other than skin) Yes ❑ No ❑ Type? _____

Dementia Yes ❑ No ❑

Diabetes Yes ❑ No ❑

Endocarditis Yes ❑ No ❑

Heart Murmur Yes ❑ No ❑

Hepatitis C Yes ❑ No ❑

HIV Yes ❑ No ❑

High Blood Pressure Yes ❑ No ❑

Heart Attack Yes ❑ No ❑

Hypothyroidism Yes ❑ No ❑

Kidney Failure Yes ❑ No ❑

End Stage Renal Disease Yes ❑ No ❑

CrCl Less than 50 Yes ❑ No ❑

Solid Organ Transplant Yes ❑ No ❑ Type? _____

Stroke Yes ❑ No ❑

TIA Yes ❑ No ❑

Joint Replacement Yes ❑ No ❑

Prosthetic Joint Infection Yes ❑ No ❑

Valve Replacement Yes ❑ No ❑

Stents Yes ❑ No ❑

Mohs Surgery Yes ❑ No ❑

Please List **ALL** other surgeries: (Example: Appendectomy)

_____

_____

_____

History of skin cancers prior to current Yes ❑ No ❑

Basal cell carcinoma Yes ❑ No ❑

Squamous cell carcinoma Yes ❑ No ❑

Melanoma Yes ❑ No ❑

Please list any other medical history:

_____

_____

_____

ALLERGY & MEDICATION INFORMATION

List Current Medications with DOSAGE and HOW OFTEN you take them (including over the counter medications and creams)

_____

_____

_____

Bloodthinner: Yes ❑ No ❑ Have you stopped taking bloodthinner: Yes ❑ No ❑ If yes, how long ago? _____

Allergies to medications: Yes ❑ No ❑ List with reaction: _____

_____

SOCIAL HISTORY

Past tobacco use? Yes ❑ No ❑

Substance abuse? Yes ❑ No ❑

Current tobacco use? Yes ❑ No ❑ Type & frequency? _____

Alcohol use? Yes ❑ No ❑ Frequency? _____

How many times in the past year have you had more than 5 drinks in one day _____

Occupation? _____

FAMILY HISTORY

Do you have a family history of melanoma? Yes ❑ No ❑ **If yes: family member?** _____

Please list significant medical history of the following family members:

Mother: _____

Father: _____

REVIEW OF SYMPTOMS

Problems with bleeding	Yes ❑ No ❑	Artificial heart valve	Yes ❑ No ❑	Live alone	Yes ❑ No ❑
Headaches	Yes ❑ No ❑	Artificial joint within the past 2 years	Yes ❑ No ❑	Dialysis	Yes ❑ No ❑
Problems with scarring	Yes ❑ No ❑	Taking blood thinners	Yes ❑ No ❑	Pregnant	Yes ❑ No ❑
Thyroid problems	Yes ❑ No ❑	Defibrillator	Yes ❑ No ❑	Iodine Skin Allergy	Yes ❑ No ❑
Unintentional weight loss	Yes ❑ No ❑	Pacemaker	Yes ❑ No ❑	Live in nursing home	Yes ❑ No ❑
Night sweats	Yes ❑ No ❑	History of MRSA infection	Yes ❑ No ❑		
Depression	Yes ❑ No ❑	Problems with spitting stitches	Yes ❑ No ❑		
Immunosuppression	Yes ❑ No ❑	History of prosthetic joint infection	Yes ❑ No ❑		

Allergy to adhesive	Yes ❑ No ❑	If yes, can you tolerate non latex paper tape Yes ❑ No ❑
Reaction to epinephrine	Yes ❑ No ❑	If yes, list reaction:_____
Allergy to lidocaine	Yes ❑ No ❑	If yes, any reaction to other numbing agents Yes ❑ No ❑
Allergy to latex	Yes ❑ No ❑	If yes, have you had reaction if provider touches you with latex gloves Yes ❑ No ❑

REASON FOR VISIT

Location of skin cancer to be treated?

_____

Previous treatments for this area?

_____

_____

_____

_____

_____

_____

I hereby authorize Skin Cancer Surgery Center to release to the insurance company(s) any information acquired in the course of my examination or treatment. I agree to be fully responsible for all expenses incurred to my account in the course of my treatment and hereby assign to Skin Cancer Surgery Center any and all insurance and settlement benefits due me to the full extent of my financial obligation to Skin Cancer Surgery Center. I further understand that my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred (If patient is minor, parent or guardian sign). For further detail please reference our company Financial Policy. By signing below I acknowledge receipt of a copy of this notice. I hereby consent to medical treatment per the treatment plan established by my doctor.

Print Name _____

Patient Signature or Authorized Representative _____ Date _____

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FINANCIAL POLICY STATEMENT

We would like to thank you for choosing Skin Cancer Surgery Center and allowing us to provide your healthcare needs. Policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the lowest cost.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding our financial responsibility and payment policy.

Payment Responsibility

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the time of service. Copays and Deductible are due at the time of service up to $1,000. Payment will be accepted in cash, checks, Visa, MasterCard, or Discover. Patients needing to make payment arrangements will be referred to the Billing Office for the necessary arrangements.

The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangements for payments will be made at the clinic's discretion based on the amount.

Release of Information

By signing our Acknowledgement of Consent form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers. Medical and billing records will be on file with Skin Cancer Surgery Center for a minimum of seven years. When requesting medical records, please allow up to 30 days for release of information. Charges may apply to certain parties as allowed by Oregon law.

Patient Responsibility

Balances after insurance are due within 30 days of the insurance payment, unless other arrangements have been made with the Billing Department, the financial counselors of the clinic.

Statements are sent out on a monthly basis and it is required by the clinic that balances be paid within 30 days of the statement date. Past due accounts which have not contacted our office to set up payment arrangements may be sent to an outside collection agency for account receivable assistance. In cases where suit needs to be filed in order to recover a past-due balance, all court costs and attorney's fees will be borne by the patient/guarantor.

All services may not be covered by all insurance companies. It should be understood that by accepting the service(s), the patient/guarantor is responsible for payment regardless of the insurance coverage.
Checks returned for Non Sufficient Funds (NSF) are subject to a reprocessing fee of $25.00.

Uninsured Patients

If you are not covered by insurance, our clinic policy requires a $1,000 deposit at the time of your first visit. This deposit will be applied to the total cost of your surgery. Please contact the Billing Department to make payment arrangements prior to surgery. Surgery and subsequent follow up appointments cannot be schedule until you have payment arrangements in effect.

Out of Network Patients

If the clinic is not an in-network provider with your insurance company you may still have out of network benefits that would allow you to be seen.
In the event that your insurance carriers pays you directly for services preformed at Skin Cancer Surgery Center and/or by Skin Cancer Surgery Center you're required to turn over the check to our office within 7 days of receipt.

Outstanding Bills

The clinic reserves the right to request deposits and payment for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed. The clinic will make every effort to work with the patient on creating the appropriate payment plan if needed.

If the account is not paid in full or payment and/or payment arrangements haven't been made within the allowed time frames, the clinic reserves the right to refer the account to an attorney and/or collection agency for collection of the balance.

Patient Scheduling

Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic's Financial Policy on the first initial visit. By signing the bottom of the Financial Policy at the initial appointment the patient/guarantor acknowledges receipt of copy of the clinic's Financial Policy.

Attendance Policy

If you should need to cancel or re-schedule any appointment please call the office at least 72 hours in advance for surgery and 24 hours in advance for follow ups. If you miss an appointment and fail to contact our office as described above, you will be charged a fee of $200.00. If you arrive more than 15 minutes late for your appointment we reserve the right to cancel your appointment. If you repeatedly miss or reschedule your appointment, you may be referred back to your doctor.

Acceptance of Insurance

The clinic will submit a bill to the insurance carrier(s) on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient/guarantor of financial responsibility. The patient/guarantor will be responsible for payment in full on all claims not paid within the allowed period of time (see patient responsibility). The clinic will make every effort to verify insurance coverage, deductible, acceptance of payment for services and other limits for the patient as a courtesy.

Pre-Certification

The clinic will make every effort to pre-certify all services and procedures that are required, provided the clinic is supplied with the necessary and correct information. In addition, the clinic will make every effort to certify ongoing authorizations as needed. It is however, the responsibility of the patient to verify that all authorizations are on file and have been approved by the insurance company.

Rejected Claims/Services Not Covered

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available and we will make every effort in helping get your claims and services covered, we cannot act as a mediator on your behalf.

The Administration and Management welcomes the opportunity to discuss any aspect of the Financial Policy. We appreciate your confidence and strive to provide you with the best quality healthcare.

I have read the Skin Cancer Surgery Center Financial Policy Statement and agree to the payment policies and understand my patient responsibilities.

Print Name

Signature of Patient or Authorized Representative

Date: SSN:

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AUTHORIZATION TO DISCUSS MEDICAL/FINANCIAL INFORMATION

AUTHORIZATION TO DISCUSS MEDICAL/ FINANCIAL INFORMATION In accordance with federal government privacy rule implemented through Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss medical/ financial information with members of your family and other individual that you designate other than insurance companies and third party payer and their agents. Please initial all that apply.

Medical_____ Financial_____ Medical and Financial_____

❑ I do not authorize Skin Cancer Surgery Center to verbally discuss medical/financial information to anyone.

❑ I do authorize Skin Cancer Surgery Center to verbally discuss medical/financial information with:

_____

Name (please print) Relationship Phone Number

_____

Name (please print) Relationship Phone Number

_____

Patients Signature Date

You have the right to revoke this authorization at any time, provided that you do so in writing.