

## **Frequently Asked Questions about Mohs Micrographic 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 Mohs 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 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 two weeks after the procedure to have them removed.

### **3. 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.

### **4. 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.

### **5. How many stitches/sutures will I have?**

The number of stitches that you need is determined by the type of closure that Dr. Nalovic uses, the location on your body, 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.

### **6. 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 works closely with other specialists with whom we will coordinate your care.

### **7. 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.

### **8. How long will it 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 cancer may be bigger under the surface and we would not know until we have started the procedure and the doctor has looked at your cancer 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 time.

### **9. 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.

### **10. 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.

### **11. Will my insurance cover this procedure?**

Yes. This is a medically necessary procedure.

**12. 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.

**13. 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. Self-prescribed over the counter medications containing aspirin, ibuprofen, or vitamins should be discontinued if possible.

**14. 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 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.

**15. 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 your surgical site or causes your blood pressure to elevate is contraindicated and could compromise the way you heal.

**16. When can I exercise?**

The resting period that we recommend after your surgery depends on where your cancer is located. Typically, we recommend that you do not exert yourself for one week if your cancer is on your head or neck area. This restriction is increased to two weeks when your cancer is on the trunk and 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.

**17. Do I need to have the doctor look at the site before I have surgery?**

Yes. The doctor 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.

**18. Will I have a follow-up appointment with the physician?**

Your follow-up status will be determined by the physician at the time your procedure is complete. Depending on the complexity of your case, you will either be scheduled for an in-office post-operative follow-up appointment, or you will be given a follow-up phone call by our office approximately 8-weeks post surgery to evaluate your progress. Of course, you may call our office at any time you have any questions or concerns.

**19. 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, we look at the skin/tissue under a microscope in order to see if the borders or outside edges of the skin that we 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 we got all of the remaining cancer cells in our first try and we do not need to take any more skin from the area.

**20. 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 20 years or so back. 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.com](http://www.aad.com) or [www.skincancerfoundation.org](http://www.skincancerfoundation.org).

**21. 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 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.

**22. 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. 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 eyes or lips, etc.

**23. 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. When we schedule your procedure, we reserve a 3 hour space. It is very difficult for us to find another one on short notice. 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.

**\*Please note: We require 48-hours notice when cancelling/rescheduling a surgery. Surgeries cancelled with less than 48-hours notice may incur a \$150 cancellation fee.**

**24. 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, iPod or a friend.



**Katarina G. Nalovic, 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: _____ Patient's Last Name: _____ First Name: _____ Middle Name: _____ Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Date of Birth (mm/dd/yyyy): _____ Age: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Home Phone #: _____ Cell Phone #: _____ Best # to Reach You: _____ Other Family Members seen here: _____ Referring Physician: _____	Is this your legal name? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, what is your legal name? _____ Former name: _____ Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/> Race: _____ Ethnicity: _____ Preferred Language: _____ Social Security Number: _____ Occupation: _____ Employer: _____ Work Phone #: _____ Referred by: Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/>
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**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.

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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.

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Patient Signature (Guardian/Power of Attorney)

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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](http://www.atlantaskincancerspecialists.com) for directions to our Buckhead location.

