

Frequently Asked Questions about an Excision Surgery

1. Will it hurt?

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

2. Will 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 lesion has been successfully removed, our doctor's expertise lies in the reconstructive component of the surgery. If the lesion 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 surgery. It is very difficult to determine how long you will be with us until we have seen you. On average, excision procedures last approximately 45 min to an hour.

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?

Generally, yes, as 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 surgery is located. Typically, we recommend that you do not exert yourself for one week if your surgery is on your head or neck area. This restriction is increased to two weeks when your surgery is on the trunk 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 excision surgery is the right treatment for you before you undergo surgery. Because some of our patients are quite elderly or live far away, we usually 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. Can I postpone the surgery*?

We do not recommend doing so. Your doctor has sent you here for us to remove your lesion 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 1 hour space. It is very difficult for us to find another one on short notice. Delaying surgery could allow your lesion to grow larger, making the reconstruction and your recovery more complicated.

***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.**

20. 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.

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"/> |
|--|---|

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:** _____

Notice of Patient Rights & Responsibilities

1. **Buckhead Mohs Surgical Center, LLC (BMSC)** recognizes and respects human rights. No patient of **BMSC** 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 or national origin.
2. It is the policy of **BMSC** that its patients and/or their representatives may exercise their rights without fear of reprisal.
3. **BMSC** 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.
4. **BMSC** 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. If the patient is unable to give consent, the patient must be accompanied by an individual with a **Power of Attorney** for the patient.
5. **BMSC** 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. **BMSC** will also provide, upon request, information regarding the company, its providers and its services.
6. **BMSC** 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 **BMSC** from obligation to provide treatment.
7. 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 **BMSC**.
8. **BMSC** will provide patients, upon request, an itemized copy of his/her bill, along with payment policies. The source of payment shall be confidential. Upon request, patients will also be provided a list of services provided and associated fees.
9. **BMSC** has policies and procedures in place to assure marketing and advertising is not misleading.
10. Patients of **BMSC** have the right to refuse to participate in experimental research.
11. Patients of **BMSC** have the right to be informed in advance of their procedure date that **BMSC** does not honor Advance Directives.
12. **BMSC** 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 or concerns about any aspect of their care or experience with **BMSC**. Please be assured that expressing a concern or complaint will not compromise patient care and will be addressed according to our policy. Concerns may be directed to any Department Head or the Practice Administrator, or you may mail your comments to us at: 3525 Piedmont Road NE, Bldg. 6, Ste. 220 Atlanta, GA 30305

Complaints may also be shared with the following:

Department of Community Health
Healthcare Facility Regulation Division
2 Peachtree Street NW, Suite 31-144
Atlanta, Georgia 30303
404-656-4507

Patients who are Medicare Beneficiaries may also contact the Office of the Medicare Beneficiaries Ombudsman: <http://www.cms.hhs.gov/ombudsman/resources.asp>

Patient Responsibilities:

1. **BMSC** expects patients to provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
2. **BMSC** requires patients to make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
3. **BMSC** 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. **BMSC** expects patients to provide a responsible adult to drive them home and stay with them 24 hours after surgery, if required by the physician.
5. **BMSC** requires patients provide us with a written notice of an Advanced Directive (e.g. a living will).
6. **BMSC** expects patients to promptly accept financial responsibility for any charges not covered by his/her insurance.
7. **BMSC** expects that its property, staff and other patients and their family be treated courteously and with respect. Patients must adhere to these responsibilities.

NOTIFICATION OF OWNERSHIP AND ADVANCE DIRECTIVES

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.

Buckhead Mohs Surgical Center, LLC (BMSC) is owned by Katarina G. Chiller, MD. The physician/owner, Dr. Chiller, 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 Buckhead Mohs Surgical Center, LLC.

By signing below, you, or your legal representative, acknowledge that this disclosure has been made in advance of the date of the procedure, and that you have decided to have the procedure performed at Buckhead Mohs Surgical Center, LLC.

Patient's Signature _____ Date _____

ADVANCE DIRECTIVES

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

In the event of a medical emergency or other life-threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care.

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

I have read and acknowledge that BMSC does not honor Advance Directives.

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

If the patient is unable to sign or is a minor, please sign.

Relative/Guardian's Signature _____ Date _____

Witness 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 and/or Buckhead 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.

Authorized Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

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

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

Your Protected Health Information

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

For Payment

For Health Care Operations

For Treatment Activities

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

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

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

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

Your Rights

Under federal law, you have the right to:

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

How we protect information

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

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Also, where required by law, our partners and vendors must protect the privacy of data we may share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Complaints

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

Contact Information

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

Practice Administrator
3525 Piedmont Road
Bldg. 6, Ste. 220
Atlanta, GA 30305
Office: 404-446-3200

Copies and Changes

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

Patient Consent for Use and Disclosure of Protected Health Information

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

With my consent, Atlanta Skin Cancer Specialists, PC (ASCS) and/or Buckhead Mohs Surgical Center, LLC (BMSC) 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 and/or BMSC 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/BMSC 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/BMSC 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/BMSC 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/BMSC may decline to provide treatment to me.

Patient Signature (Guardian/Power of Attorney)

Date

Directions

Atlanta Skin Cancer Specialists, PC and Buckhead Mohs Surgical Center, LLC are conveniently located next door to each other in Piedmont Center right off of **GA 400** in Buckhead. Please call our office at (404) 446-3200 if you require further instructions on locating us.

Atlanta Skin Cancer Specialists, PC Buckhead Location

&

Buckhead Mohs Surgical Center, LLC

Conveniently located at:

Piedmont Center
3525 Piedmont Road
Bldg. 6, Suite 220
Atlanta, GA 30305

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

Directions from GA 400:

Located minutes off 400

- Exit **Buckhead**/Lenox Road (Exit #2)
- Go **WEST** at exit, **away** from Phipps/Lenox Malls
- Lenox Road dead ends into Piedmont Road
- Take a **RIGHT** onto Piedmont Road (Roy's restaurant on your right)
- Go through one (1) light.
- Take next entrance on **RIGHT** (same entrance as **SunTrust Bank**) Stay on the upper level of the parking deck and continue towards the back of the building on your left.
- Our suite faces the back parking lot and is **ONLY** accessible from the **OUTSIDE** of the building; it is on the corner of the building farthest from Piedmont Road – **Free Parking**

Directions from 285:

- 285 West - Turn **LEFT** off the Roswell Road Exit
- 285 East - Turn **RIGHT** off the Roswell Road Exit
 - Proceed on Roswell Road approximately 5 miles
 - Turn left onto Piedmont Road (the Landmark Diner will be on your right)
 - Go approximately 1/4 of a mile
- Turn **LEFT** into Piedmont Center (same entrance as **SunTrust Bank**) Stay on the upper level of the parking deck and continue towards the back of the building on your left.
- Our suite faces the back parking lot and is **ONLY** accessible from the **OUTSIDE** of the building; it is on the corner of the building farthest from Piedmont Road – **Free Parking**