GRANGER MEDICAL CLINIC | *Dermatology*

Deductible: _____
Acct #: _____

Mohs Day Health History Update

Name: _____ Date: _____

Please check any that apply today:

□ Fever

□ Chills

□ Nausea

□ Anxiety

□ Bleeding problems

□ Current infections

□ Artificial joint replacement in the last 2 years

□ Artificial heart valve

□ Pacemaker/Defibrillator

□ History of organ transplant

□ Recent chemo therapy/low white blood count

□ Allergies to latex, band aids or any medications?

□ Other _____

□ None of the above

GRANGER MEDICAL CLINIC | Dermatology

Michael R. Hinckley, MD

Mohs Surgery Consent

As with any surgery, Mohs Micrographic Surgery is associated with possible risks and complications. Pain, infection, bleeding and multiple other complications may occur during or after surgery. Minor, serious, or life-threatening reactions can occur with the use of anesthetics or with medicines given before, during or after surgery. Nerves controlling muscle movement sensation, or other functions may be damaged. This damage may be permanent. When reconstructing surgical defects, a number of complications may occur including but not limited to infection, bleeding, scarring, significant deformity, and other potential risks. Reconstruction of the wound defect may require more than one surgical procedure.

I have read the above information and have discussed any questions or concerns with Dr. Michael Hinckley. I have been informed of alternative treatments and the potential complications of the procedure. I understand that no guarantee is made regarding the outcome of the surgery and I ask that the surgery be performed.

I authorize and consent to the taking of photographs before, during and after surgery, and at the follow up visits. I understand that the photographs are primarily for medical documentation of my surgery. They may also be used for medical education, lectures, and publication in medical journals. I understand that no identifiable photograph of me will be published without my consent.

Signature: _____

Printed Name: _____

Date: _____ Patient ID#: _____

Witness Signature: _____

GRANGER MEDICAL CLINIC | *Dermatology*

Michael R. Hinckley, MD

Mohs Missed Appointment & Late Cancellation Policy

Granger Medical Dermatology values all of our patients and their needs.

Our goal is to provide exceptional care to all of our patients in a timely matter. If you find that you are unable to attend your appointment, a 24-hour cancellation notice is required.

This requirement allows our office adequate time to coordinate care for another patient.

Please be aware that we do charge a $300.00 missed appointment and or late cancellation fee.

I _____ have read this policy and understand that I will be responsible for a $300.00
(Please print name)

fee if I fail to call and cancel or no show my scheduled appointment. I ask that a copy of this policy be made so I can keep one for my records at home.

Yes _____ No _____

_____ _____

Patient Signature Date

(If patient is a minor) Legal Guardian Signature _____

FOR OFFICE USE ONLY

A copy was made by _____and given to the patient.

_____ _____

Employee Signature Date

Patient Account #:_____

GRANGER MEDICAL CLINIC | *Dermatology*

Important Billing Information

If you have a harmless growth (such as brown spots or other benign growths) we are happy to treat them but insurance is NOT likely to cover these, as they may be considered "cosmetic".

If we treat something that is precancerous or cancerous those are not considered cosmetic but depending on your insurance YOU MAY HAVE TO MEET A DEDUCTIBLE BEFORE INSURANCE WILL PAY FOR A PROCEDURE.

If we biopsy or remove a suspicious growth we will send it to the pathologist to determine the diagnosis. As a result, you may also get a bill from the pathologist if you have not met your deductible.

I understand the billing process for the procedure(s) I am undergoing.

Print Patients Name: _____

Patient's Signature: _____

(If patient is a minor, the signature of the guardian)

Date: _____

FOR OFFICE USE ONLY

Patient account #: _____

Witness Signature: _____

GRANGER MEDICAL CLINIC | *Dermatology*

What is MOHS Micrographic Surgery?

In 1937, Dr. Fredrich Mohs, (a later Nobel Prize nominee) developed a technique for the surgical removal of skin cancers. This technique provides patients with the highest chance of cure.

What is skin cancer? Cancer is a tissue, which grows at an uncontrollable and unpredictable rate. There are three main forms of skin cancer: basal cell carcinoma, squamous cell carcinoma, and malignant melanoma.

Is it dangerous? The most common types of skin cancer are basal cell carcinoma and squamous cell carcinoma. These types typically do not spread to distant parts of the body. If not completely removed, they can invade and destroy structures in their path of growth.

What causes skin cancer? Excessive exposure to sunlight is the most important factor associated with the development of skin cancers, which appear most commonly on the face and arms. Other possible factors contributing to the development of skin cancer includes x-rays, trauma, and certain chemicals.

How does skin cancer start? Skin cancer begins in the upper-most layer of the skin and grows downward and along the surface of the skin. What is apparent to the naked eye on the surface of the skin may only be the "tip of the iceberg".

How is it removed? Using Mohs Micrographic Surgery, your cancer will be removed as follows:

1. After the area has been numbed, the visible portion of the cancer or the area of the biopsy will be removed with a thin layer of normal appearing tissue around the area.
2. The edge and base of the tissue will then be examined under a microscope. If any remaining cancer cells are seen, the surgeon will go back and take more tissue in the area the cancer was seen.

How long does it take? Removal of skin cancer depends on how wide or deep it may be growing and the flow of the laboratory. After the surgery, a decision is made as to the best way to manage the wound created by the surgery. This will be discussed later. This process may take the whole day.

How effective is Mohs' Micrographic Surgery? Using the Mohs technique, the percentage of success can be as high as 97% to 99% for basal cell carcinoma and almost as high for squamous cell carcinomas. There is no other treatment with this success rate.

What are the advantages of Mohs' Micrographic Surgery? Besides the high cure rate, this technique allows the physician to pinpoint areas of cancer and selectively remove those areas. Thus, the surgeon tries to minimize the amount of tissue removed while still removing the cancer.

Will the surgery leave a scar? Yes. However we make an effort to obtain an optimal cosmetic result for the patient and may work in conjunction with another reconstructive surgeon if necessary.

How much does the surgery cost will my insurance pay? Mohs surgery is outpatient surgery. Medicare accepts almost all of the total charge and will reimburse you 80% of their accepted charge. If you have a second insurance policy or co-insurance this should pay the major portion of the remaining bill. For those who do not have Medicare, the amount that your policy will pay toward the cost of the surgery varies with the type of policy you have. If you have any questions concerning this you can call your insurance company. We will be glad to help file your insurance claims; however, the patient will be responsible for any balance not covered by insurance.

How should I prepare myself for Mohs' Micrographic Surgery? Eat a good breakfast. If you are taking any medications, take them as usual unless we direct otherwise. If you take warfarin ("Coumadin") please notify our office at 801.965.2799. We will ask you to have your warfarin level ("INR" or "Protime") checked shortly before surgery do not discontinue any blood thinners prescribed by your physician. If you take aspirin for preventative reason only (you have never had a heart attack, blood clot or stroke), please discontinue the aspirin 2 weeks before surgery. Also discontinue supplements that can thin blood: Vitamin E, Fish Oil, Feverfew, Gingko Biloba, Ginseng, Ginger, or Garlic. Moreover, please do not drink any alcohol for two days before or after surgery.

How long does the surgery take? Each step of the surgical procedure takes about 10-30 minutes. Following surgery, it might take over one hour for the slides to be prepared for microscopic examination. Several surgical stages and microscopic examinations may be required. We recommend you bring a book or something else to keep you occupied while waiting. You may want to bring food or money in case you are here past lunch and would like to buy food during one of the waiting periods.

Should someone come with me on the day of surgery? Yes. Please have someone accompany you or plan to drop you off and pick you up. We ask that you limit the number of people accompanying you to one or two people because of limited space in our waiting room. No small children please.

Is there pain associated with the surgery? A local anesthetic (typically lidocaine) will be used, to numb the skin around the cancer. Please inform us if you experience anything more than slight discomfort. It is understandable to be nervous about this procedure and we are happy to prescribe a medication that can be taken the night before and the day of surgery. This medicine can relax you but might make you drowsy so you definitely need a driver if you choose to take the medicine. Please inform us prior to surgery if you are interested in having us order you some medication.

What happens the day of surgery? The area will be anesthetized and then Dr. Hinckley will remove the area of the cancer as previously described. It usually takes 15 to 30 minutes to anesthetize the involved area and to remove the tissue. The removed tissue will be sent to the laboratory for processing. It will take 1 to 2 hours to prepare the tissue for microscopic examination and examine the slide. While you are waiting, you are free to leave the area for refreshments, just alert us first. If the tissue removed still contains cancer cells, the procedure will be repeated. You will be photographed before treatment as well as after surgery and again after healing. These photographs become part of your medical record and may be used for teaching purposes.

What happens after the cancer has been removed? When we have determined that the skin cancer has been completely removed, a decision is made on what to do with the wound created by the surgery. We will involve you with the decision-making. Usually we will close the wound with stitches but sometimes we may choose to let the wound heal by itself.

What happens during the wound healing process? You may experience a sensation of tightness as the wound heals, but this is normal. Frequently, tumors involve nerves and it may take up to one year or even two, before feeling returns to normal or near normal. Sometimes the area stays numb permanently. The new skin that grows over the wound contains many more blood vessels than the skin that was removed. This results in a red scar and the area may be sensitive to temperature changes. This sensitivity improves with time and the redness gradually fades. If you are having discomfort, avoid extremes of temperatures. Patients frequently experiences itching after their wound has healed because the new skin that covers the wound does not contain as many oil glands as previously existed. Plain petroleum jelly ("Vaseline") or other skin moisturizer will help relieve the itching. Some patients may have a tendency to form large, thick scars. If this appears to be happening, you can return to the clinic and we will put some medicine in the scar to try to stop the growth.

How often must I return for a follow up? Our practice is to have patients return to their referring physician for visits every 6-12 months, depending on what the referring physician determines. Patients initially seen in our office will return here. Experience has shown that if there is a recurrence of skin cancer, it usually will be within the first year following surgery. Once you develop a skin cancer, there is a possibility that you will develop others in the years ahead. We recommend that your dermatologist see you at least once a year for the rest of your life. If you notice any suspicious areas on your skin, see your physician to have it evaluated.

If my skin cancer has been treated several times will it ever be cured? One reason for Mohs surgery is that other forms of treatment have failed. Because Mohs' Surgery uses microscopic control to search out the roots of the cancer, it cures almost all patients— even those in whom skin cancer has persisted in spite of several other treatments

Later on must I avoid the sun? No. Provide yourself with adequate protection, avoid burning, and use discretion. Each morning, apply a liberal amount of a lotion containing sunscreen with a SPF of 15-30 or greater to exposed areas of face, neck, scalp, and ears. It is best to apply the sunscreen about 20 minutes before going outside. Use a SPF of 50 or higher if you plan to be outside for longer periods of time. Reapply sunscreen every few hours and after swimming or exercising. Even more effective than sunscreens are a wide- brimmed hat for your scalp and ears and other protective clothing for other areas of the body.

Thank you for entrusting us with your skin care needs!

To watch a video of the Mohs procedure paste the following address into your Internet browser:
https://www.skincancermohssurgery.org/about-mohs-surgery/overview-of-mohs-micrographic-surgery
Then click on the link that says: "View broadband version"

GRANGER MEDICAL CLINIC | *Dermatology*

Deductible: _____
Acct #: _____

New Patient Form

Michael R. Hinckley, MD *Jack Saunders, PA-C*

Date: _____ Patient Name: _____ Gender: ☐ M ☐ F DOB: _____
Pharmacy: _____ Primary Care Physician: _____
What are you being seen for today?
1. _____
2. _____

Medications currently taking (If numerous, please provide us with a copy of your list):
_____

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what type?_____
Over the years has your sun exposure been: *(please circle one)* Mild Moderate Excessive

Social History

Marital Status:	☐ Single	☐ Married	☐ Widowed
Are you Pregnant or Nursing?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	

Family History
History of skin cancer? ☐ Yes ☐ No If yes, who and what type? _____

Review of Systems
How are you feeling today? ☐ Feeling Well ☐ Feeling Fair ☐ Feeling Poorly
Do you have allergies/reactions to medications? ☐ Yes* ☐ No
*If Yes, what medication(s) and symptom(s)? _____

Are you allergic to Band-Aids or tape?	☐ Yes	☐ No		
Difficulty with wound healing?	☐ Yes	☐ No		
Prone to large scars/keloids?	☐ Yes	☐ No		
Prone to infection?	☐ Yes	☐ No		
Bleeding Problems	☐ Bleed easily	☐ N/A		
Lumps under skin *(nodes)*	☐ Neck	☐ Armpits	☐ Groin	☐ N/A
Eyes	☐ Grittiness	☐ Dry	☐ N/A	
Psychological	☐ Anxiety	☐ Depression	☐ N/A	
Musculoskeletal	☐ Joint pain swelling	☐ N/A		
Head	☐ Headache	☐ Dizziness	☐ N/A	
Sensitive Stomach *(to pills)*	☐ Yes	☐ No		
OTHER SKIN PROBLEMS	☐ Yes	☐ No		

YOUR Current & Past Medical Conditions

Defibrillator or pacemaker	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Joint replacement	☐ Yes ☐ No	Neurological disease	☐ Yes ☐ No
Organ transplant	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
HIV infections	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No

GRANGER MEDICAL CLINIC

Patient Registration Form

Patient Information (Please print)

Patient legal name: _____ Gender: ☐ Male ☐ Female ☐ Other
Last name First Name MI Maiden

Mailing address: _____ Marital status: ☐ Single ☐ Widowed
Street City State Zip

Home phone: _____ Preferred contact method: ☐ Married ☐ Divorced

Work phone: _____ ☐ Home ☐ Work Date of birth: ____/____/____

Cell phone: _____ ☐ Cell ☐ Text ☐ Email SSN#: _____

Email address: _____ *In accordance with federal guidelines, please indicate the following:

Employment: ☐ Not employed ☐ Employed: _____ Preferred language: If not english _____

Referring provider: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary care provider: _____ Race: ☐ American Indian or Alaska Native ☐ Asian

Preferred pharmacy: _____ ☐ Black or African American ☐ White

Address: _____ Phone: _____ ☐ Native Hawaiian or Pacific Islander ☐ Other Race

Do you have a Living Will? ☐ Yes ☐ No Do you have an Advanced Directive? ☐ Yes ☐ No

Would you like access to your health information online through our healow app/patient portal? ☐ Yes ☐ No

How did you hear about us? _____

Responsible Party

Name: _____ Phone: _____

Relation to patient: _____

Parents of Patient

Father's name: _____ Mother's name: _____

Home address: _____ Home address: _____

Phone: _____ DOB: _____ Phone: _____ DOB: _____

Employer: _____ Employer: _____

Insurance Information

Primary Insurance

Insurance company: _____

Subscriber's name: _____

Subscriber's date of birth: _____

Subscriber's ID#: _____

Group #: _____

Patient's relationship to subscriber: _____

Secondary Insurance

Insurance company: _____

Subscriber's name: _____

Subscriber's date of birth: _____

Subscriber's ID#: _____

Group #: _____

Patient's relationship to subscriber: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

****PLEASE PROVIDE YOUR INSURANCE CARD AND INFORMATION AT CHECK-IN****

FORM CONTINUES ON NEXT PAGE

Medical Information Release to Assigned Parties

In my absence, I authorize Granger Medical Clinic to release all or portions of my, or my dependents, medical record(s) to those as indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. Please consider others who may bring your children in for care, such as a relative or guardian.

Name:_____ Relationship:_____ Guardian:_____

☐ Medical release and consent to treat Phone:_____

Name:_____ Relationship:_____ Guardian:_____

☐ Medical release and consent to treat Phone:_____

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____

Consent for Treatment, Releast of information, & Assignment of Benefit

I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of Granger Medical Clinic may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing. By signing below, I authorize Granger Medical Clinic to disclose my protected health information, the release of medical information to process my claim(s). As a courtesy to our patients, will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company, is responsible for payment of this account.

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____

Notice of Privacy Practices

I acknowledge that I have received a copy of Granger Medical Clinic's NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used.

I understand that no authorization is required from me in order for Granger Medical Clinic to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____

Notification of Appointments/Treatment/No Shows

Thank you for respecting the time we have reserved for you by providing at least a 24 hour notice, should you need to cancel or reschedule. For no show visits, please be advised that you may be assessed a No Show fee for missed appointments - some may be charged at the cost of the visit or service. If recurrent no shows become an issue, a deposit may be required to hold future appointments. Patients will receive a courtesy text, voice, and/or email reminder, sent out prior to your appointment. Whether received or not, please be advised that it is the patient's responsibility to remember their appointment date and time.

Credit and Finance Charge Policy and Agreement

I agree to provide accurate updated insurance and personal demographic information each visit. I agree to be financially responsible for costs incurred (in my, or my dependent's care). I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by Granger Medical Clinic on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to Granger Medical Clinic (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

All delinquent accounts may be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 33% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees in addition to the collection fee.

You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls and/or text messages to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls and/or text messages from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Granger Medical Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____