PORTLAND DERMATOLOGY CLINIC LLP

1414 NW Northrup, Ste 600
Portland, Oregon 97209
ph: 503 223-3104
www.portlanddermclinic.com

Mohs Surgery Welcome Kit

Ken K. Lee, M.D., P.C.
PORTLAND DERMATOLOGY CLINIC LLP

1414 NW Northrup, Ste 600
Portland, Oregon 97209
ph: 503 445-2136
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PREPARING FOR SURGERY

Most patients are scheduled directly for Mohs or excision surgery without a preoperative visit. A consultation will be done on the day of the procedure. It is important that you read this page carefully and fill out the Patient Health Questionnaire, available on our website at www.portlanddermclinic.com/surgery.

If you want to learn more about Mohs surgery or excision, the website also contains additional information. If you would like to see Dr. Lee in consultation prior to the surgery date, we will gladly schedule an appointment upon request.

The surgery is performed under local anesthesia. We suggest that you eat a normal breakfast or lunch, unless otherwise specified. Please bathe or shower and wash your hair to minimize your risk of a surgical site infection.

It is important that you do NOT take any anti-anxiety medicines, narcotic pain medicines or similar types of medicines on the day of the surgery. If needed, we will provide you with an anti-anxiety medicine once you have signed the consent form. For Mohs surgery, you will be here for several hours, so bring a book, magazine, or laptop. For excisions, you will be here for approximately 1 hour. We recommend that you have someone accompany you to give you a ride home. This is a requirement if you receive anti-anxiety medicines.

It is essential that you are able to positively identify the biopsy site on which surgery will be performed. If you cannot, please let us know ahead of time. You may need to go to your referring physician to have the site marked.

Many patients are on blood thinning medications that are prescribed by their physicians. We do not recommend stopping them without explicit permission from the prescribing physician. For those on Coumadin/Warfarin, please make sure that your INR is in the therapeutic range. Please stop taking any aspirin or anti-inflammatory medicines (like ibuprofen, Advil, Motrin, Naprosyn, Anacin and Bufferin), alcohol, vitamin E, ginko biloba and garlic pills at least one week before your surgery. They can increase your risk of bleeding during surgery. **If your physician recommends aspirin please do not discontinue without permission.**

If your referring physician did not make the surgery appointment for you, please call our office at 503-445-2136. Please have the name and number of the referring physician along with your insurance card ready, when you call. We are happy to address any other questions you may have at that time as well.

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DRIVING DIRECTIONS

Walter G. Larsen, MD, PC
Michael J. Adler, MD, PC
Barbara E. Resnick, MD, PC
Rebecca A. Bremner, MD
Jonathan S. Alexander, MD
Renee M. Chang, MD
Ken K. Lee, MD, PC

Portland Dermatology Clinic, LLP is located in the Machine Works Building, look for the building with the big red stripe. Parking garage entrance is located on 15th (between Northrup and Marshall).

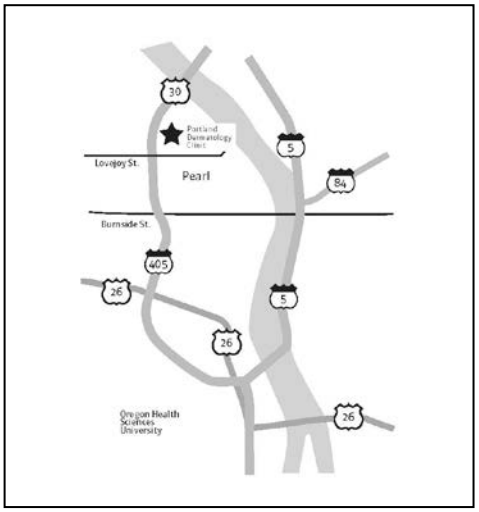
From the North via I-5:
Take Exit 302A toward city center.
Turn slight right onto Broadway.
N. Broadway becomes Broadway Bridge.
Turn right onto NW Lovejoy St.
Take 2nd right onto NW 10th Ave.
Take 2nd left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, then left into parking garage
Park on the 5th floor and take the elevator
up to the clinic on the 6th floor.

From the East via I-84
Merge onto I-5 N/US-30W toward Seattle
Take Exit 302A toward Rose Quarter/Broadway-Weidler St.
Off ramp becomes NE Victoria Ave., continue straight
Turn Left onto NE Broadway
NE Broadway becomes Broadway Bridge
Turn right onto NW Lovejoy St.
Take 2nd right onto NW 10th Ave.
Take the 2nd left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, turn left into parking garage
Park on the 5th floor and take the elevator
Up to the clinic on the 6th floor.

From the West via Hwy 26
Merge onto I-405 via exit on the left towards St. Helens/Seattle
Take exit 2B-Everett St.
Follow the rest of the directions from the South via I-5

From the South via I-5:
Merge onto I-405 N via Exit 299B on the left, toward US-26 W/City Center/Beaverton.
Take Exit 2B toward Everett St.
This exit turns into NW 14th Ave.
Take left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, turn left into parking garage
Park on the 5th floor and take the elevator
up to the clinic on the 6th floor.

From the West via Hwy 30 (St. Helens)
Take Highway 30 toward SE Santosh St.
Keep right at the fork, follow signs for I-405 S/US 26/Salem
And merge onto 1-405 S
Take exit 2B toward Everett St
Merge onto NW 16th Ave
Turn left onto NW Everett St.
Take the 2nd left onto NW 14th
Take left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, turn left into parking garage
Park on the 5th floor and take the elevator
up to the clinic on the 6th floor.



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HEALTH QUESTIONNAIRE

Name_____ Birthdate_____
Home phone_____ Mobile phone_____
Occupation_____ Work phone_____
Referring Physician_____ Phone_____
Address_____
Primary Care Physician_____ Phone_____
Address_____
Pharmacy_____

Reason for Visit_____

All Current Medications and Dosage: Please use separate page if needed

1_____ 2_____
3_____ 4_____
5_____ 6_____

Are you allergic to any medications (include latex and anesthetics)? Please list with type of reaction.

_____

Do you take blood thinner, Aspirin, anti-inflammatory (e.g. ibuprofen, Motrin, Advil), Vit E? Yes___ No___

If yes, list _____

Do you take antibiotics before dental procedures? Yes___ No___ If yes, what antibiotic: _____

Are you prone to or have any of the following?	**YES**	**NO**	**EXPLAIN**
Diabetes	____	____	_____
Pacemaker/Defibrillator	____	____	_____
High blood pressure	____	____	_____
Artificial valve	____	____	_____
Heart disease	____	____	_____
Bleeding tendency	____	____	_____
Artificial joint	____	____	_____
Hepatitis or liver disease	____	____	_____
Kidney disease	____	____	_____
Eye problems	____	____	_____
Keloids/abnormal healing	____	____	_____
HIV or other immunodeficiency	____	____	_____
Organ transplantation	____	____	_____
Nerve damage or stroke	____	____	_____
Breathing problems (asthma/emphysema)	____	____	_____
Emotional disorders	____	____	_____
Cold Sores	____	____	_____

-continued on reverse-

Please list any other significant skin and medical problems_____

_____

Do you smoke? Yes____No____How many packs/day?_____

Do you drink alcohol? Yes____ No____How much?_____

Are you pregnant or breastfeeding? Yes____ No____

Have you had a skin cancer? Yes____ No____

If yes, type (basal cell carcinoma, squamous cell carcinoma, melanoma), treatment and date:

_____

_____

_____

Do you have a family history of melanoma? Yes____ No____

Have you had Mohs surgery before? Yes____No____ If yes, site of surgery and surgeon:

_____

_____

Have you been diagnosed with cancer other than skin? Yes____ No____If yes, type, date & treatment:

_____

_____

Have you had surgeries in the past? Yes____ No____If yes, type and date:

_____

_____

Cosmetic Consultation: Please list previous cosmetic procedures (Laser, Botox, Fillers, and Surgeries)

_____

_____

_____

Additional Comments: _____

_____

_____

Patient signature _____ **Date** _____

Reviewed by/date _____ _____

_____ _____ _____

PORTLAND DERMATOLOGY CLINIC LLP

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ DOB: ___/___/___ Date ____/_____/_____

Receipt of Privacy Practices:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ **Date** _____/_____/_____

FINANCIAL POLICY:

Portland Dermatology Clinic (PDC) is pleased to participate in a large number of different insurance plans. While we are pleased to participate in these plans patient's individual coverage is not verified by our office staff prior to appointments. Patients should contact their insurance companies directly for any coverage questions they may have. Co-pays and deductibles usually apply to office visits and treatments performed at PDC. If the insurance company denies payment or only pays a portion of the medical bill, the patient will be responsible for payment of the remaining balance.

____Patients with insurance (not including Medicare):

Patients are asked to bring their current insurance identification card to each appointment. If your insurance information is not received within 1 business day of your appointment, the balance incurred from your visit will be your responsibility and your insurance will not be billed. Co-payments are due at time of service. Patients are responsible for paying insurance deductibles, co-insurance, and any services not covered by insurance.
For patients on insurance plans in which our doctors are not contracted, as a courtesy, we will submit a claim to your insurance company. A down payment of $216 is due at the time of service. **PATIENTS SCHEDULED FOR MOHS SURGERY, please contact our billing department for payment arrangements**. Any additional services will require a payment of 35% of the total bill at the time of service.

____Patients without insurance (Private Pay):

Payment is due in full at the time of service. Please note, if you have a procedure your specimen may be sent out for tissue processing which could prompt an additional bill from our preferred laboratory.

____Cosmetic Procedures:

Payment for any cosmetic procedure is due at time of service. Certain procedures require a prepayment to hold the appointment. This payment is kept as a deposit and will be applied to the consultation with the doctor.

Agreement:

I understand that if my account becomes delinquent, it may be assigned to a collection agency and a $25 late fee will be accessed. I have read and understand the Portland Dermatology Clinic Financial Policy. My signature below indicates that I accept this policy and agree to abide by the terms for my treatment at the Portland Dermatology Clinic.

Patient or Responsible Party Signature_____ Date _____/_____/_____

MEDICARE PATIENT'S SEE REVERSE SIDE

Medicare Subscribers

Medicare Payment Policy:

_____We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $162.00 deductible and paying for the 20% copayment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed.

Please sign so we may have your Medicare Authorization on file:

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

Signature: _____ Date: _____/_____/_____

Please sign so we may have your Supplemental Authorization on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____/_____/_____

Note: If you have recently joined (or changed) to a Medicare Advantage plan, please let our staff know so we can update your records and advise you if we are participating providers.

Please present Medicare and secondary insurance card(s) and a photo ID to the receptionist so copies may be made.