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 **Dr. David Kao** and **Keleigh Nersasian PA-C** to treat your skin cancer.

Melanoma In-Situ is skin cancer in the very early stages, affecting only the top layer of skin. MIS is excised with a margin that is sent to an outside lab for examination. Because the outside lab requires the tissues to be processed overnight you will be bandaged immediately following the initial stage of the procedure and sent home to await the results. If the Dermatopathologist determines that the margins are not clear, you will have to return to the clinic for further excision. This procedure is repeated until the margins are completely clear.

Finally, when the MIS is deemed clear, the resulting surgical defect may then be reconstructed.

Important information for your surgery

Please complete and bring with you:

- ☐ Patient Questionnaire
- ☐ Financial Policy

- ❑ 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 not to take** 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 prescribed by your doctor for atrial fibrillation, stents in heart, blood clots, stroke or other medical condition.*

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.

ALKA SELTZER
ADVIL
ANACIN
ANAPROX (Aleve)
APC
ASA
ASCODEEN
ASCRIPTION
ASPIRIN
BUFFERIN
BRUFEN
CEPHALGESIC
CHERACOL CAPSULE
CHILDREN'S ASPIRIN
CHLOROQUINE
CORICIDINE
DARVON
DARVON WITH ASA
DOLOEID
DRISTAN
EASPRIN
ECOTRIN
EMPIRIN
EMPRAZIL
EXCEDRIN
FELDENE
FISH OIL/OMEGA 3
FLORINAL
GARLIC
GINKGO BILOBA
IBUPROFEN
INDOCIN
INDOMETHACIN
MEDIPREN
MIDOL
MOTRIN
MULTIVITAMINS
NALFON
NAPROSYN
NORGESIC
NUPRIN
PERCODAN
PHENAPHEN
ROBAXISAL
RUFIN
SINE OFF
SINE AID
TRANDATE
TRENTAL
TRIGESIC
TRILISATE
VANQUISH
VITAMIN E
VOLTAREN
ZACTRIN
ZORFRIN

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

David M. Kao, MD, PC
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 ❑

Race: ❑ American Indian/Alaskan ❑ Asian ❑ Black /African American ❑ Pacific Islander ❑ White ❑ Other ❑ Unknown ❑ Decline

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Decline Language: ❑ English ❑ French ❑ German ❑ Russian ❑ Spanish ❑ Decline

Employer _____ Address _____

Spouse Name _____

Home Phone _____ Cell Phone _____

Emergency Contact _____

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 _____

Address _____

_____

Subscriber Name _____ ID # _____

Relationship to Patient _____ DOB _____

SECONDARY

Insurance Name _____

Address _____

_____

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 David M. Kao, MD, PC, 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 _____

Limited Messages

_____

_____

_____

If you would like to authorize verbal communication with family members and/or friends, you may request to fill out a "Permission for Verbal Communication" form with the front desk.

PLEASE BE SURE TO COMPLETE ALL 3 PAGES OF THE APPLICATION

PHARMACY INFORMATION

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

Pharmacy Name _____ Location _____

Phone _____

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.

ALLERGY & MEDICATION INFORMATION

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

Allergies to latex or rubber gloves: Yes ❑ No ❑

Allergies to local anesthesia: Yes ❑ No ❑

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

_____

_____

_____

Do you take antibiotics before dental work? Yes ❑ No ❑ Why? _____

Do you take Aspirin or another blood thinner? Yes ❑ No ❑ Which one? _____

If so, did you contact prescribing physician? Yes ❑ No ❑ When did you stop taking? _____

Do you have a pacemaker? Yes ❑ No ❑ Do you have a defibrillator? Yes ❑ No ❑

If female: Are you/do you think you may be pregnant? Yes ❑ No ❑

MEDICAL HISTORY

Artificial Heart Valve Yes ❑ No ❑

Asthma Yes ❑ No ❑

Autoimmune Disease Yes ❑ No ❑ Type? _____

Basal Cell Nevus Syndrome Yes ❑ No ❑

Blood Disorders Yes ❑ No ❑

Type? _____

Cancer (other than skin) Yes ❑ No ❑

Type? _____

Dementia Yes ❑ No ❑

Diabetes Yes ❑ No ❑ Type 1 or 2?_____

Eczema/Atopic Derm Yes ❑ No ❑

Foot/Ankle Swelling Yes ❑ No ❑

Heart Murmur Yes ❑ No ❑

Hepatitis Yes ❑ No ❑ Type? _____

HIV Yes ❑ No ❑

High Blood Pressure Yes ❑ No ❑

High Cholesterol Yes ❑ No ❑

Irregular Heartbeat Yes ❑ No ❑

Type?_____

Heart Attack Yes ❑ No ❑

Solid Organ Transplant Yes ❑ No ❑ Type? _____

Stroke/TIA Yes ❑ No ❑

Thyroid Disorder Yes ❑ No ❑

Type? _____

Please list any other medical history not mentioned:

_____

_____

_____

_____

Previous Skin Cancers: Yes ❑ No ❑ (basal cell, squamous cell or melanoma)

When/Where? _____

Previous Mohs? Yes ❑ No ❑

List All Surgeries:

_____

_____

_____

_____

_____

FAMILY HISTORY

Have these health problems occurred in your family? (natural parents, brothers, sisters, grandparents.)

Bleeding Disorders Yes ❑ No ❑ Who in your family had these conditions? _____

Cancer Yes ❑ No ❑ Who in your family had these conditions? _____

Skin Cancer Yes ❑ No ❑ Who in your family had these conditions? _____

Heart Disease/Heart Attacks Yes ❑ No ❑ Who in your family had these conditions? _____

Other (please list any additional) _____

SOCIAL HISTORY

Occupation? _____

Do you live alone? Yes ❑ No ❑

If no, who do you live with? _____

Alcohol use? Yes ❑ No ❑ Frequency? _____

Current tobacco use? Yes ❑ No ❑

Type & frequency? _____

Past tobacco use? Yes ❑ No ❑

Substance abuse? Yes ❑ No ❑

Explain: _____

REASON FOR VISIT

Location of skin cancer to be treated?

_____

How long has this area been an issue?

_____

Symptoms associated with the area:

Bleeding Yes ❑ No ❑ Pain Yes ❑ No ❑

Redness Yes ❑ No ❑ Tingling Yes ❑ No ❑

Numbness Yes ❑ No ❑ Itching Yes ❑ No ❑

Previous treatments for this area?

_____

_____

_____

_____

_____

_____

REVIEW OF SYMPTOMS

Fever/chills	Yes ❑	No ❑	Fast heart beat	Yes ❑	No ❑	Back pain	Yes ❑	No ❑
Unintentional weight loss	Yes ❑	No ❑	Foot/ankle swelling	Yes ❑	No ❑	Neck pain	Yes ❑	No ❑
Blurred vision	Yes ❑	No ❑	Cough	Yes ❑	No ❑	Fungal infection	Yes ❑	No ❑
Eye drainage	Yes ❑	No ❑	Shortness of breath	Yes ❑	No ❑	Rash	Yes ❑	No ❑
Eye pain	Yes ❑	No ❑	Wheezing	Yes ❑	No ❑	Hives	Yes ❑	No ❑
Ear pain	Yes ❑	No ❑	Abdominal pain	Yes ❑	No ❑	Memory loss	Yes ❑	No ❑
Nasal congestion	Yes ❑	No ❑	Nausea	Yes ❑	No ❑	Tremor	Yes ❑	No ❑
Sore/ulcer in mouth	Yes ❑	No ❑	Vomiting	Yes ❑	No ❑	Weakness	Yes ❑	No ❑
Chest pain	Yes ❑	No ❑	Joint pain	Yes ❑	No ❑	Excessive bleeding	Yes ❑	No ❑

Do you have a Living Will? Yes ❑ No ❑ If Yes, where is it on file? _____

I hereby authorize David M. Kao, MD, PC 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 David M. Kao, MD, PC any and all insurance and settlement benefits due me to the full extent of my financial obligation to David M. Kao, MD, PC. 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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skin cancer surgery center
drdavidkao.com

FINANCIAL POLICY STATEMENT

David M. Kao, MD, PC
Physician and Surgeon
Specializing in Mohs Micrographic Surgery

We would like to thank you for choosing **David M. Kao, MD, PC** 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 David M. Kao, MD PC 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 David M. Kao, MD PC 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. If you miss an appointment or fail to contact our office as described above, you will be charged a fee of of $200.00 for a surgical appointment. 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 David M. Kao, MD PC 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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skin cancer surgery center
drdavidkao.com

Informed Consent for Surgical Excision of Malignancy

I, _____, hereby authorize Dr. David Kao to perform a surgical excision. I fully understand what will happen to me during the day on which Dr. Kao will operate on me.

I understand that the excision is performed under local anesthesia to remove the malignancy.

I also understand that there may be possible complications including but not limited to bleeding, infection, and temporary or permanent loss of sensation to the skin in the surgical area. Loss of motor function of a nerve (facial muscle movement) is unusual, but may occur for tumors which extend deep. The removal of the skin cancer will result in a scar. There may be recurrence of the cancer.

I understand the procedure/treatment and additional services which are or may be necessary, as well as related risks and alternatives. I am satisfied with the information Dr. Kao has given me. My questions concerning the operation and its possible outcome have been answered to my satisfaction.

I also give Dr. Kao permission to take photographs of my skin lesion and/or any tissue removed before the operation during and/or immediately after the operation, as well as on subsequent office visits. I understand that these photographs may be used for educational purposes and may be published in professional journals or medical books. However, in such an event, I will not be identified by name. Furthermore, I expect no compensation for these photographs and waive all rights to any claims for payment or royalties. I also release Dr. Kao from any liability in connection with the use of such photographs.

I also do hereby authorize and direct Dr. David Kao to retain and obtain complete custody and control of all medical records, tissue slides, photographs, or medical charts pertaining to any medical and surgical treatment of skin cancer received by me from any physician or medical personnel within the past seven years.

I understand that I may withdraw this consent at any time prior to the procedure/treatment. I also understand that no warranty or guarantee has been made as to the result or cure.

X _____

Patient Signature **Date/Time**

_____ _____

Patient's Authorized Representative **Relationship**

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drdavidkao.com

ACKNOWLEDGEMENT AND CONSENT OF HEALTH INFORMATION

David M. Kao, MD, PC
Physician and Surgeon
Specializing in Mohs Micrographic Surgery

Notice of Privacy Practices

I understand that **David M. Kao, MD, PC,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Portal Disclaimer

David M. Kao, MD PC office offers secure online viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physician electronically. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation.

This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the web site uses secure sockets layer technology, you can read or view information on your computer. This information is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to gain access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures on the patient portal, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

By signing below, I agree that I have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices.

❑ I also agree to electronic communication through the internet patient portal system. Email: _____

Print Name: _____

Patient Signature_____ Date _____

_____ _____

(If unable to sign, patient's Authorized Representative) (Relationship)