Atlanta Skin Cancer Specialists, PC

Katarina G. Lequeux-Nalovic, MD
3525 Piedmont Road NE Building 6, Suite 220 Atlanta, GA 30305
3330 Preston Ridge Road, Suite 280, Alpharetta, GA 30005
Phone: (404) 446-3200 Fax: (404) 446-3201

PRE-OPERATIVE INSTRUCTIONS

1. Please eat breakfast / lunch prior to your appointment.

2. You may take your regular medication on the day of surgery. It is important that you bring a list of your medications and allergies with you. If you are unable to make a list, please bring all of your medications with you.

3. Unless you are on aspirin by a doctor's order, please refrain from taking aspirin for 3 weeks. Non-steroidal anti-inflammatory medications such as Motrin, Advil, Alka-Seltzer, or Ibuprofen should be discontinued for ONE WEEK prior to surgery. Vitamin E supplements should also be stopped for at least one week. We typically do not require you to discontinue any prescribed blood thinners (Coumadin or Plavix, for example). If you have a bleeding disorder, call our office to let us know.

4. In general, antibiotic prophylaxis is NOT indicated for skin surgery, even if you have artificial joints or valves.

5. Notify our office if the site that will be operated on is growing or changing rapidly.

6. Notify our office if you require special accommodations.

7. After your surgery you may be scheduled to return to the office in 8 weeks for a follow-up. Typically, you will be asked not to plan ***extended*** vacations immediately following surgery. You ***may*** need to be available 7-10 days after your surgery for a suture removal visit. You will also need to refrain from heavy lifting and strenuous activity after surgery for optimal healing of the surgery site. If this is not feasible, please call our office immediately to reschedule your appointment.

8. Please take a photo of your surgical site on your cell phone or other mobile camera and bring it with you or return to your general dermatologist so that they can identify the site for you, create a diagram, and/or take a picture. (We must be sure that you can point it out at the time of surgery or we will need to reschedule your appointment.)

9. Please arrive 20 minutes early for your appointment or we may need to reschedule you. Other patients deserve to be seen on time.

We require <u>48 HOURS NOTICE</u> to cancel an appointment. Other patients may need to be accommodated and we appreciate the opportunity to adjust our schedule accordingly. You will be charged a $150.00 cancellation fee if you cancel your appointment within 48 hours of your scheduled time.

For any scheduled surgery appointments that are missed without notification, there will be a $500.00 no show fee.

When you receive your statement from this procedure, there will be an invoice for the doctor's fee, an invoice for the surgery center, and you may receive a separate bill from the pathology laboratory if biopsies are obtained.

We look forward to meeting you! If you have any questions or concerns, please call our office.

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 or Dr. Arnold 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 after your surgery to evaluate your progress. Of course, you may call our office at any time you have any questions or concerns and we will see you that same day if we believe it to be urgent. This is our "open door policy"- Please call us first as we do have two locations and want to make sure we are there to see you.

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.
    ***<u>Please note</u>: 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.

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Patient Information	
Today's Date:_____	Is this your legal name? Yes ❑ No ❑
Patient's Last Name:_____	If no, what is your legal name? _____
First Name:_____	Former name: _____
Middle Name:_____	Married ❑ Divorced ❑ Separated ❑
Preferred Name: _____	Widowed ❑ Single ❑ Partnership ❑
Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑	Sex: M ❑ F ❑
Date of Birth (mm/dd/yyyy):_____ Age: _____	Race: _____ Ethnicity: _____
Street Address: _____	Preferred Language: _____
City:_____ State: _____Zip:_____	Social Security Number: _____
Home Phone #: _____	Occupation: _____
Cell Phone #: _____	Employer: _____
Best # to Reach You:_____	Work Phone #: _____
Other Family Members seen here: _____	Referred by: Doctor ❑ Family ❑ Friend ❑ Other ❑
Patient E-mail Address:_____	Referring Physician:_____

In Case of an Emergency	
Name of local friend/family member (not at same address):	
Relationship:	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, Alpharetta Mohs Surgical Center, Buckhead Mohs Surgical Center, or my insurance company to release any information required to process my claims.

Patient Signature:_____ **Date**: _____

Medications and Supplements

Please list any prescription medications and over-the-counter medications you are currently taking including aspirin containing products, vitamins, and supplements.

Medication	Dose	Frequency	Reason for Taking

Are you allergic to any medications?	Yes ☐	No ☐	If yes, please list below

Pharmacy Information

Name:_____ Phone:_____

Street:_____ City:_____

Notice of Patient Rights & Responsibilities

1. **Alpharetta Mohs Surgical Center, LLC & Buckhead Mohs Surgical Center, LLC (THE FACILITY)** recognizes and respects human rights. No patient of **THE FACILITY** 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, national origin, language or disability.
2. It is the policy of **THE FACILITY** that it patients and/or their representatives may exercise their rights without fear of reprisal.
3. **THE FACILITY** 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. **THE FACILITY** 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. **THE FACILITY** 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. **THE FACILITY** will also provide, upon request, information regarding the company, its providers and its services.
6. **THE FACILITY** 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 THE FACILITY 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 **THE FACILITY**.
8. **THE FACILITY** 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. **THE FACILITY** has policies and procedures in place to assure marketing and advertising is not misleading.
10. Patients of **THE FACILITY** have the right to refuse to participate in experimental research.
11. Patients of **THE FACILITY** have the right to be informed in advance of their procedure date that THE FACILITY does not honor Advance Directives.
12. **THE FACILITY** 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 THE FACILITY. 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:
https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Responsibilities:

1. **THE FACILITY** expects patients to provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
2. **THE FACILITY** requires patients to make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
3. **THE FACILITY** 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. **THE FACILITY** 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. **THE FACILITY** requires patients provide us with a written notice of an Advanced Directive (e.g. a living will).
6. **THE FACILITY** expects patients to promptly accept financial responsibility for any charges not covered by his/her insurance.
7. **THE FACILITY** 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.

Alpharetta Mohs Surgical Center, LLC & Buckhead Mohs Surgical Center, LLC (THE FACILITY) is owned by Katarina G.Lequeux-Nalovic, MD. The physician/owner, Dr. Katarina G. Lequeux-Nalovic, 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 Alpharetta Mohs Surgical Center, LLC & 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 Alpharetta Mohs Surgical Center, LLC or 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, THE FACILITY requires each patient, **prior to scheduled procedures**, to read and acknowledge THE FACILITY'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 THE FACILITY. As a facility-wide policy, and in good conscience, The Facility does not honor Advanced Directives. The Facility is afforded this right by the Georgia Department of Human Services, and in compliance with Georgia State and Federal law.

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 THE FACILITY 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_____

Financial Policy

This is an agreement between Atlanta Skin Cancer Specialists, PC, and/or Alpharetta Mohs Surgical Center and/or Buckhead Mohs Surgical Center, as creditors, and the Patient/Debtor named on this form.

In this policy the words “you”, “your” and “yours” mean the Patient / Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Atlanta Skin Cancer Specialists, PC, and/or Alpharetta Mohs Surgical Center and/or Buckhead Mohs Surgical Center.

Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance card at the time of visit, we may be forced to reschedule your appointment.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-payment, deductible and co-insurance. It is your responsibility to pay any deductible, co-pay or any portion of the charge as specified by your plan. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of the charges at each visit.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges that is not covered by insurance.

Claims submission. As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Payments. Unless other arrangements are approved by us in writing, you are responsible to pay your balance prior to services being rendered. If we have to send you a statement, balance on your statement is due and payable upon receipt. Monthly statement will show separately all services performed, the finance charge, if any, and payments or credits applied to your account. Statement will show only charges that have patient portion of the balance. Those charges that have been paid will not appear on the statement. *Please note that we do not accept cash payments.*

Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless approved by us in writing. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Financial Assistance. If you need financial assistance, we can help you to apply for CareCredit. You also can visit www.Carecredit.com for more information and apply online.

Missed appointments. Our policy is to charge for missed appointments. If you do not show up for an appointment, or cancel with less than 48 hours notice, there will be a missed appointment fee of $150. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Returned checks. There is a fee (currently $35) for any checks returned by the bank. It is our policy to not accept personal check for future appointments in this situation.

Refunds. Because our policy is to collect payment at the time of service based on the information provided by your insurance company, we may find ourselves in a situation to refund you money once your claim has processed. By signing this agreement, you agree to deposit the refund check within 60 days. If you lose, misplace, or otherwise forget to do so in that time frame, we will be glad to provide you with a replacement check, which you will pick up in person. You will be responsible to pay for the bank cancelation fee and any additional administrative fees of the original refund check. Any refund due to the patient that is under $25, will be refunded through the credit card used on the date of service (when applicable).

Waiver of confidentiality. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your "past due" status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Damage to hearing Aids and other removable devices. We strongly recommend that hearing aids and any easily removable device worn by the patient is removed during the surgical procedure. ASCS accepts no financial responsibility or liability for damage done to these devices during surgical procedure if not removed.

Effective date. Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient/Guardian: _____

Responsible party (if not the patient): _____

Signature: _____ Date: _____

PAYMENT OF FEES

Full payment is expected at the time of service. If we accept your insurance reimbursement, 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, Discover and American Express, as well as personal checks. We do not accept cash payments. If your check is returned to us by your bank for any reason we will charge you the maximum fee allowed by law at that time. Your visit with us may involve two facilities and these will need to be paid for individually. In other words, you may need to make two separate payments for two entities.

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 10% fee of balance due. 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 _____

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 local dermatopathology practices. If your insurance requires you to use a specific 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 and our Business Associates and their subcontractors 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 is information about you, including demographic information, that identifies you and that relates to your past, present or future physical or mental health condition and related health care services.

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.

How we use your PHI:

1. For Payment

2. For Health Care Operations We may use or disclose your PHI, as necessary, to contact you at home or another designated location to remind you of your appointment.

3. For Treatment Activities

4. For You: Release of medical records require written request

5. For 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 in writing, 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.

6. For Compliance with the 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. 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. You are allowed to request that we not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

Your Rights
Under federal law, you have the right to:

- Review this notice
- 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 disclosures of your PHI.
- You will be notified of breaches if they occur with your unsecured (PHI that is not protected by encryption or destruction according to HHS regulations) 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:

Office for Civil Rights in the U.S. Department of Health and Human Services
Regional Office IV – Atlanta
Regional Manager – Roosevelt Freeman
Sam Nunn Atlanta Federal Center

Suite 16T70
61 Forsyth St SW
Atlanta, GA 30303-8909

The contact person for our Practice from whom an individual may request additional information about the Privacy Rule or file a complaint is the Practice Administrator and 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 Signed Consent

By signing this form you consent that you have read and understand Alpharetta Mohs Surgical Center, Buckhead Mohs Surgical Center and Atlanta Skin Cancer Specialists HIPAA Notice of Privacy Practices, and that you consent to THE FACILITY and ASCS using your protected health information in the manner described above. I also consent to the use of 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/THE FACILITY 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.

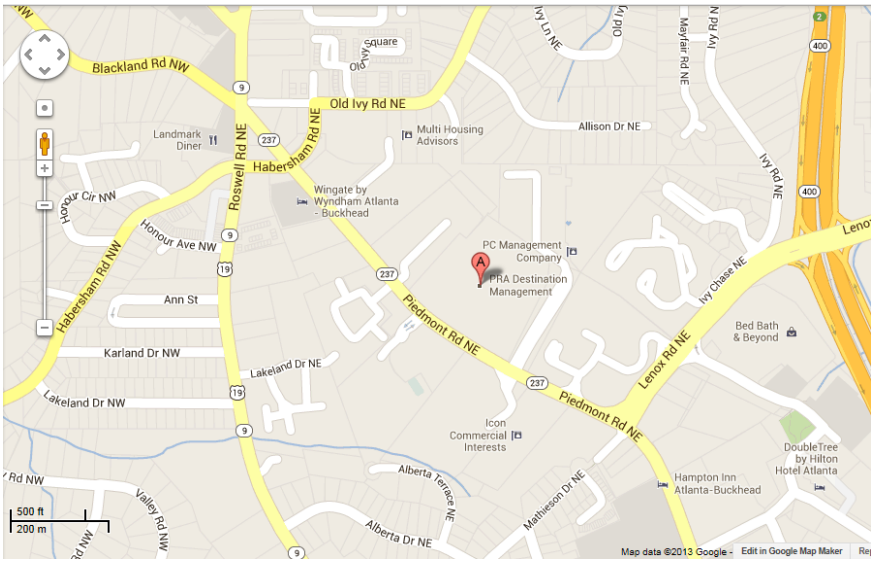
Atlanta Skin Cancer Specialists, PC Buckhead Location

&

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**. 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. 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**