SKIN CANCER CENTRE
MOHS MICROGRAPHIC SURGERY

Name: _____ Chart #: _____

Date of Birth: _____

1) Please check the reason(s) for your visit today:

_____ Check lesion or changing mole
_____ Skin Cancer
_____ Referred by another doctor for any of the above
_____ Other (please specify) _____

2) List medicine(s) you take on a regular basis:

_____
_____
_____

3) List allergies to medicine(s) you may have (Penicillin, Sulfa, etc.)

_____
_____

4) Do you take aspirin often or daily? ___(Yes) ___(No)

For Office Use Only

Abbreviations commonly used in Medical Records**:**

Dx	- Diagnosis	MSOR	- Minor Surgery Operative Report
BCC	- Basal cell carcinoma	O2 Sat	- Oxygen Saturation
SCC	- Squamous cell carcinoma	TAC	- Triamcinolone
AK	- Actinic Keratosis	Bx	- Biopsy
SK	- Seborrheic Keratosis	Rx	- Treatment
OS	- Office Surgery	NEOR	- No Evidence Of Recurrence
ED&C	- Electrodessication and curettage	IL	- Intralesional
RJD	- Richard J. DeAngelis	IM	- Intramuscular
DOB	- Date of Birth	LN2	- Liquid Nitrogen
BP	- Blood Pressure	LPLK	- Lichenoid Keratosis

1409 N. Fant Street Anderson, SC 29621
864-231-8599 or 1-800-972-3751 Fax: 864-231-8073

Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, payment is due at the time of service. Our office accepts payment by cash, check, Visa or MasterCard, and American Express.

Our fees reflect the usual and customary charges for this area. However, our fees may vary slightly from the usual and customary fees cited by insurance companies, which often include non-specialist fees and out-dated fees in their computations.

Your Insurance

We have contracts with many insurers. We will bill those plans with which we have a contract and will collect any copayment from you at the time of your service. In the event your health plan determines a service to be "not covered", you will be responsible for the charges. In that event, we will bill you and payment is due upon receipt of the statement, although, in certain circumstances, reasonable payment plans may be established.

If you have insurance coverage with a plan that we do not have an agreement with, we will prepare and send the claim for you as a courtesy. Charges for your care and treatment are due at the time of service unless other arrangements are made by you with us in advance.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I have read and understand the financial policy of The Skin Cancer Centre, P.A. and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date

Please print the name of the patient.

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM FOR USE AND DISCLOSURE OF PHI

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. By signing this form, you acknowledge that you have been provided with our **Notice of Privacy Practices** to review.

By signing this form, you also instruct this practice to release your medical and/or financial information according to the criteria listed below:

Medical and/or financial information about me may be released to:

_____Spouse: Name of Spouse: _____

_____Child(ren): Name of those authorized to receive information:_____

_____Other (non-physician): _____

Please indicate if our practice can communicate your Protected Health Information (PHI) as described below: (circle answer for each item)

Yes/No - SCC may leave a message on my answering machine or voice mail regarding an upcoming appointment.

Yes/No - SCC may leave a message with someone answering the phone number I have provided regarding an upcoming appointment.

Yes/No - SCC may leave a message on my answering machine or voice mail concerning my pathology results.

Yes/No - SCC may leave a message with someone answering the phone number I have provided concerning my pathology results.

Yes/No - SCC may leave a message on my answering machine or voice mail that I need to call your office concerning any test results or financial matters.

Yes/No - SCC may leave a message with someone answering the phone number I have provided that I need to call your office concerning any test results or financial matters.

Yes/No - SCC may release any photographs or slides of me *including electronic release through the use of E-mail* for consultation and/or training purposes with any other medical personnel as deemed appropriate by Dr. DeAngelis.

Patient Name [please print]: _____

Patient or Parent or Legal Guardian Signature: _____ Date: _____

Name [please print]: _____

(If Parent or Legal Guardian)

Relationship to Patient: □ Parent □ Legal Guardian

PATIENT INFORMATION

Name_____

Address_____

_____

Home Phone _____ Cell Phone_____

Date of Birth _____ Sex _____ Race _____

Social Security Number _____

Employment _____

Work Phone _____ Spouse _____

E-mail Address _____

RESPONSIBLE PARTY INFORMATION (If Patient is a Minor)

Name _____

Address _____

_____ Home Phone_____

Cell Phone _____ Work Phone _____

Employment _____

Social Security Number _____

INSURANCE INFORMATION

	Policy Number	**Insured**	**Effective Date**
Medicare			
Medicaid			
Blue Cross & Blue Shield			
Other			

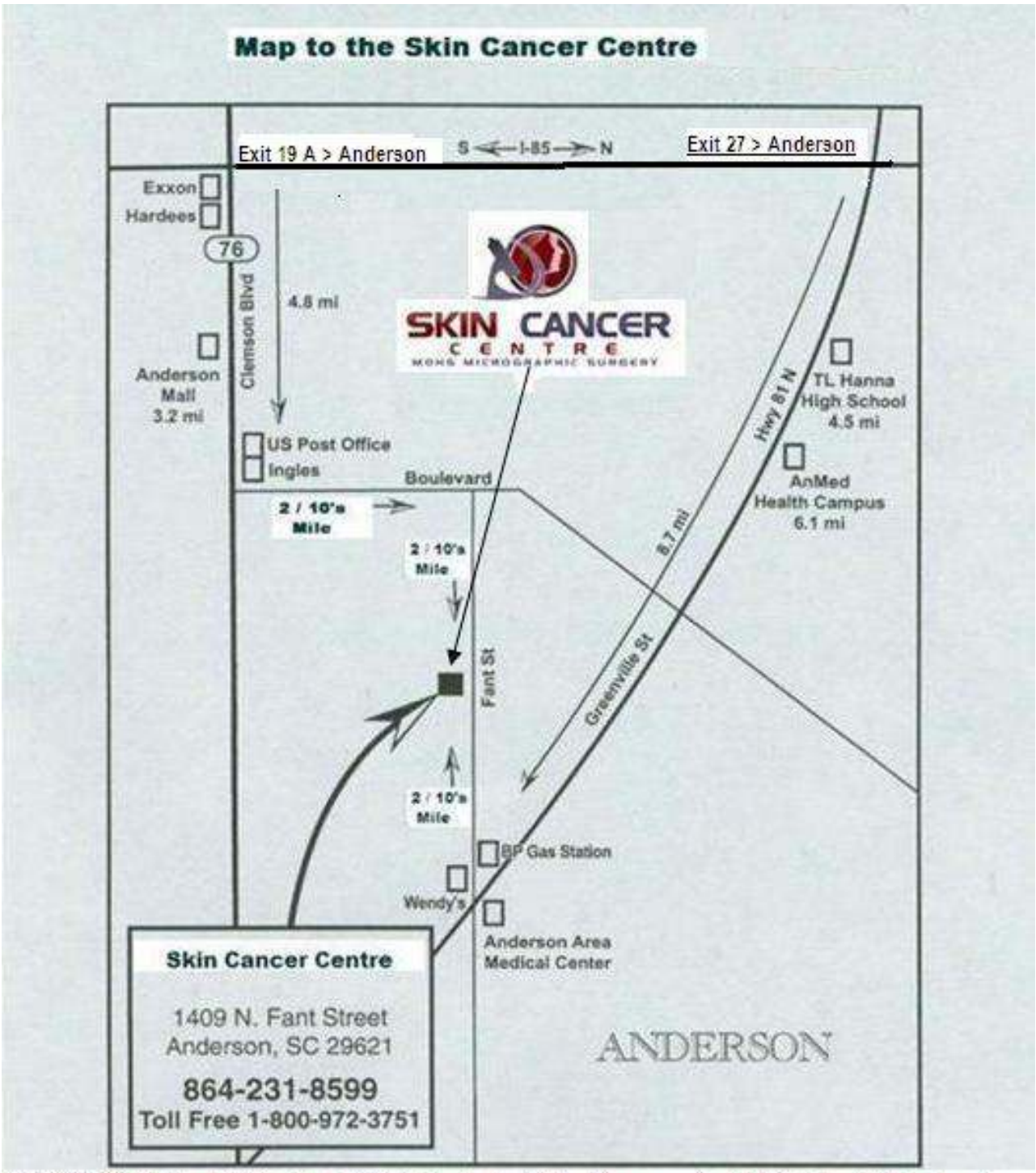
I authorize Skin Cancer Centre, to release to my insurance companies any information required for services provided. I permit a copy of this authorization to be used in place of the original and request that payment of insurance benefits are assigned to Skin Cancer Centre.

I understand that I remain responsible to the Skin Cancer Centre, for any and all charges not met by the payment of the assignment above and for all charges should said payment not be paid within a responsible time after charges are filed with the insurer.

_____ _____

Responsible Party Patient's Signature

Map to the Skin Cancer Centre



From Greenville: Hwy I-85 South to Exit 27, Left onto Hwy 81N., drive approximately 8.7 miles to the intersection of Greenville St. and N. Fant St.. Turn Right onto N. Fant St., go about 3 blocks (0.2 miles), office is on the Left. Skin Cancer Centre - 1409 N. Fant St.

From GA: Hwy I-85 North to Exit 19-A Merge onto Clemson Blvd., drive approximately 4.8 miles until you see US Post Office and Ingles on the Left. Turn Left onto Boulevard, go to the next traffic light, turn Right onto N. Fant St.., go 2 blocks (0.2 miles), office is on the Right. Skin Cancer Centre - 1409 N. Fant St.