

Libbyette E. Wright, M.D.
Informed Consent for MOHS Surgery

Patient Name: _____ Date: _____ Time: _____

Diagnosis requiring procedure: Mohs Surgery For Skin Cancer _____

Please read and initial the items below.

- _____ I hereby request and authorize Dr. Wright, aided by her assistants, to perform MOHS micrographic & reconstructive surgery on me on or about the _____ day of _____, 20_____ for the purpose of removing skin cancer and reconstructing the resultant defect.
- _____ I also authorize the operating surgeon to perform any other procedures that she may deem necessary or desirable in the attempt to improve the condition(s) stated above or any other unhealthy or unforeseen condition that she may encounter during the operation. I consent to the administration of anesthetics to be applied by or under the direction of Dr. Wright to the use of such anesthetics and medications as deemed advisable in my case.
- _____ I have been advised that this surgery involves external skin incisions which may leave permanent scars, as is the case in all human beings. I understand that scars may take one year or more to fully mature, usually starting out pink to red and usually fading gradually to white in the first 12 months depending on skin tone. I have been advised that in the first few months after surgery, sunlight tends to darken scars and make them more noticeable. Though most scar lines heal normally, some scars can heal abnormally thick (keloids and hypertrophic scars) or abnormally thin (atrophic scars). How scar lines heal depends on many factors, including but not limited to body location, individual variations in the healing process between patients, and quality of wound care postoperatively. I understand that additional procedures are sometimes necessary in order to obtain the best possible functional and cosmetic result and that these costs may or may not be covered by insurance. I also understand that after removal of the cancer I may have the area repaired by a plastic surgeon of my choice. If I have surgery on my leg(s) I understand the importance of limiting walking as much as possible. This includes no exercise until permission is given by Dr. Wright. I understand that leg elevation above the level of the hip is important to decrease swelling. Swelling may slow healing, cause an infection of the wound and/or result in the opening of a sutured wound. Healing may take weeks to months on the lower extremity. Therefore, I understand to assist in healing, I will limit activity, elevate the extremity and follow wound care instructions.
- _____ I agree to follow the instructions given to me by Dr. Wright to the best of my ability before, during, and after the operation, and I will, as soon as possible, notify her of any questionable conditions that may arise.
- _____ I have read and understand the handouts pertinent to my surgery. The nature and usual effects of the proposed operation, the foreseeable risks involved, and alternative methods of treatment have all been explained to me in terms that I understand. **In particular, the risks may include: bleeding, infection, excessive scarring, nerve damage, altered sensation, adverse reaction to medications, and incomplete tumor removal. Practical alternative methods of treatment include: radiation, traditional excision, cryosurgery, electrodesiccation and curettage.**
- _____ I hereby state that the information furnished as part of my comprehensive preoperative evaluation is correct.
- _____ I understand that any price quoted by The Skin Surgery Center of Houston will include physician services only and does not include outside laboratory or facility fees unless otherwise specified.
- _____ I am aware that the practice of medicine and surgery is not an exact science and, therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding this operation that I have herein requested and authorized. I have been advised that the goal of the operation I have requested is improvement of the condition and that there is a possibility that imperfection may arise and that results might not live up to my preconceived expectations.
- _____ I have been given an opportunity (Dr. Wright will consult with you before surgery) to ask questions regarding this operation and the matters covered in the preceding paragraphs, and all questions have been answered to my satisfaction.

Patient or Legal Guardian's Signature

Date

Witness Signature

Date

Libbyette E. Wright, M.D.
The Skin Surgery Center of Houston

PATIENT QUESTIONNAIRE AND HIPAA ACKNOWLEDGEMENT

Patient Name (print): _____ **Date:** _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Do we have permission to:

Leave a message on your answering machine at home? ___ Yes ___ No

Leave a message on your cell phone? ___ Yes ___ No

Leave a message at your place of employment? ___ Yes ___ No

Discuss your medical condition with a family member? ___ Yes ___ No

If yes, who? _____ Relationship _____ Telephone _____

Comment: _____

The office of Dr. Libbyette E. Wright, M.D. has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have questions, please address them with Dr. Wright during your visit with Dr. Wright.

Patient's/Guardian Signature

Date

The Skin Surgery Center of Houston

Libbyette E. Wright, M.D.

Financial Policy

Dr. Wright is committed to providing you with quality care. As a patient of Dr. Wrights, you are financially responsible for all medical services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

Patient/Insurance/Verification Information

As a patient you are responsible for providing accurate and complete insurance information. Your health insurance is a contract between you and your insurance company. It is your responsibility to contact your carrier to verify if provider is in network, coverage and payment obligations. At the time of scheduling your appointment, you will be asked to provide your insurance information. Our office reserves the right to contact your health insurance carrier to verify your coverage and payment responsibilities: this is not a guarantee of payment. If we are providers with your insurance carrier, as a courtesy to you, we will file a claim with your insurance carrier.

Again, your health insurance is a contract between you and your insurance company. We are not a party to your contract. Therefore, Dr. Wright cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for timely payment of your account.

At check-in you will be asked to provide your insurance identification card, social security number, and state-issued identification. This is for your protection as well as to ensure that no changes in coverage have occurred.

Referrals

If you have a health plan that requires a referral from your primary care physician it is your responsibility to obtain this information prior to your appointment. It is also your responsibility to verify that you do not exceed the number of visits authorized by your primary care physician/health care plan. If you exceed your authorized visits you will be billed for all services rendered. If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at the time of service.

Co-payments/Deductibles/Coinsurance

All co-payments, applicable deductibles and coinsurance amounts will be collected upon patient check-in. In compliance with our contract with your insurance carrier, Dr. Wright cannot discount/waive any co-payment, deductible and/or coinsurance amounts.

Scheduled Procedures

If you have been scheduled to have a procedure, a representative from our office will contact you with instructions and prepayment of any unmet deductible. This amount will be collected prior to your procedure date. Our office works very diligently to schedule all procedures in a timely manner and coordinate authorizations with your insurance carrier; therefore, if you request to reschedule a procedure, our office requests at least 48 hours notice prior to your procedure date.

Self-Pay/Non-Contracted Plans/Non-Covered Services/Third Party Claims

Payment in full will be collected at the time of your office visit.

Medicare Patients

If you have regular Medicare part B and a secondary carrier (Medi-Gap plan) we will not collect any payment at the time of your visit. Our office will bill you for any portion of your bill not paid by Medicare and your secondary carrier.

If you have regular Medicare Part B only and have not met your deductible, we will collect the deductible amount along with your 20% coinsurance at the time of your visit.

If you have regular Medicare Part B only and have met your deductible, we will only bill your 20% coinsurance at the time of your visit.

Out of Network Patients

Any applicable deductible, co-payment, coinsurance, and non-covered services will be collected at the time of your office visit. Please contact your insurance carrier for guidelines pertaining to your coverage.

Laboratory Authorization

Skin samples are sometimes sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory if my insurance doesn't pay or I am a self-pay patient.

Medical/Billing Records Requests/Patient Document Requests

All records requests must be submitted in writing and must include a signed release from the patient. The fee for each of these requests is \$38.00, which is required prior to any records being released. All records requests will be processed within 30 days from the receipt of payment.

Patient Balances

Any patient balance due after your insurance company has processed your medical charges will be billed: this balance is due upon receipt. If the balance is not paid or payment agreement established, your account will be forwarded to an outside collection agency within 90 days of the first billing statement.

Upon arrival for an appointment, any outstanding balance due will be collected at check-in.

Methods of Payment

Our office accepts cash, check (with proper identification), Debit, VISA, Discover and MasterCard.

- I have received a copy of Dr. Wright's Financial Policy, which I have read and understand.
- I understand that I am personally responsible for payment on my account.
- In the event my insurance company deems a service to be "non-covered", I understand that I am personally responsible for payment.

Patient's/Guardian Signature: _____ Date: _____

Printed Name: _____