

## Demographic Sheet

Required information for Registration and your Electronic Medical Record

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Suffix: \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ SS # \_\_\_\_\_ Occupation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Same as Cell Phone Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  None Email: \_\_\_\_\_  No Email

Contact Preference:  Home Phone  Cell Phone  Work Phone  Home Address

Race: \_\_\_\_\_  declined Ethnicity: \_\_\_\_\_  declined

Primary Language:  English  Spanish  Other \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Partner

How did you hear about us? \_\_\_\_\_

**GUARDIAN:** Do you have a Guardian?  Yes  No If yes, please provide name below.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Suffix: \_\_\_\_\_

### EMERGENCY CONTACT:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Suffix: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  Home Phone  Cell Phone  Work Phone

**GUARANTOR:** PARENT OR RESPONSIBLE PARTY (if different from patient)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Suffix: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Guarantor SS#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_  Home Phone  Cell Phone  Work Phone

Email \_\_\_\_\_  No Email Date of Birth: \_\_\_\_\_

### PRIMARY CARE PROVIDER:

Office Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  M.D.  D.O.  PA-C  N.P.  Other \_\_\_\_\_

### REFERRING PROVIDER:

Office Phone Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  M.D.  D.O.  PA-C  N.P.  Other \_\_\_\_\_

**INSURANCE INFO:** Please present *insurance card* and *driver's license* during check in. Complete **only** if you're **not** the policy holder.

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to policy holder \_\_\_\_\_ Relationship to policy holder \_\_\_\_\_

## HIPAA Omnibus Notice of Privacy Practices | Effective Date: April 1, 2015 | Revised: July 25, 2019

*This notice describes how medical information about you may be used and/or disclosed and how you can get access to this information. Please review it carefully.*

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information (PHI). "PHI" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

**1. USES AND DISCLOSURES OF YOUR PHI** We may use and disclose your PHI in the following situations:

**Treatment:** We may use or disclose your PHI to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

**Payment:** Your PHI will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

**Health Care Operations:** We may use and disclose your PHI to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Minors:** PHI of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

**Required by Law:** We will use or disclose your PHI when required to do so by local, state, federal, and international law.

**Abuse, Neglect, and Domestic Violence:** Your PHI will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

**Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your PHI for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

**Law Enforcement:** We'll disclose your PHI for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

**Coroners/Medical Examiners:** We disclose PHI to coroners/medical examiners to assist in fulfilling their work responsibilities and investigations.

**Public Health:** Your PHI may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

**Health Oversight Activities:** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, licensures & other activities as authorized by law.

**Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose PHI to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

**Military, National Security and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your PHI to authorized officials

**Immunizations:** We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

**Worker's Compensation:** We will disclose only the PHI necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

**Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your PHI will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

**Breach Notification Purposes:** If for any reason there is an unsecured breach of your PHI, we'll utilize the contact information you have provided us to notify you of the breach, as required by law. In addition, your PHI may be disclosed as a part of the breach notification and reporting process.

**Research:** Your PHI may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

**Business Associates:** We may disclose your PHI to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your PHI.

**2. USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT**

**Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your PHI may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

**Disaster:** In the event of a disaster, your PHI may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

**Fundraising:** As necessary, we may disclose your PHI to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

**3. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION** We will not disclose or use your PHI in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

**Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

**Disclosures for marketing purposes** and sale of your PHI.

**4. PROTECTED HEALTH INFORMATION (PHI) & YOUR RIGHTS** The following are statements of your rights, subject to certain limitations, with respect to your PHI:

**You have the right** to inspect and copy your PHI (reasonable fees may apply): Pursuant to your written request, you have the right to inspect and copy your PHI in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the PHI and may charge a fee for the associated costs.

**You have a right** to a summary or explanation of your PHI: You have the right to request only a summary of your PHI if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

**You have the right** to obtain an electronic copy of medical records: You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your PHI is maintained in an electronic format. We'll make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required to transmit the electronic medical records.

**You have the right** to receive a notice of breach: In the event of a breach of your unsecured PHI, you have the right to be notified of such breach.

**You have the right** to request Amendments: At any time if you believe the PHI we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

**You have a right** to receive an accounting of certain disclosures: You have the right to receive an accounting of disclosures of your PHI. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

**You have the right** to request restrictions of your PHI: You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

**You have a right** to request to receive confidential communications: You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

**You have a right** to receive a paper copy of this notice: Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

**5. CHANGES TO THIS NOTICE** We reserve the right to change the terms of this notice, will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. We will not retaliate against you for filing a complaint.

**6. COMPLAINTS** If you believe your privacy rights have been violated & you'd like to register a complaint, you may do so with us or the Secretary of the United States Department of Health & Human Services.

**HIPAA Compliance Officer:**

Mark Rausch, MD, HIPAA Compliance Officer  
Christine S. Rausch MD, PC  
2510 Gaskins Road Henrico, VA 23238 | 804.282.4940 | [info@mohsvirginia.com](mailto:info@mohsvirginia.com)

**US Department of Health & Human Services:**

[www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/)  
Phone: 202.619.0257

**The Joint Commission:**

[patientsafetyreport@jointcommission.org](mailto:patientsafetyreport@jointcommission.org)  
Fax: 630-792-5636

**7. ACKNOWLEDGMENT**

I acknowledge that I have been given the opportunity to review the HIPAA Notice of Privacy Practices and that may ask to speak with the HIPAA Compliance Officer in person or by phone at the number listed above, should I have question or concerns regarding this document. I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that the scanned document is the same as the original.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Responsible Party

\_\_\_\_\_  
Relationship to Patient

## Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (NPP) provides information about how Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC may use and disclose Protected Health Information (PHI). As specified in the NPP, Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC intends to use and disclose the minimum necessary PHI about you for treatment, payment or health care operation purposes. I understand that at any time I may ask questions to Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC if I do not understand any information contained in the NPP.

I, \_\_\_\_\_, have had the opportunity to review the Notice of Privacy Practice for Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC and I was offered and;

\_\_\_\_\_ I **received** a copy of the Notice of Privacy Practices (NPP)  
INITIAL

\_\_\_\_\_ I **declined** a personal copy of the Notice of Privacy Practices (NPP)  
INITIAL

I, \_\_\_\_\_, have had the opportunity to review the Patient Bill of Rights, Advance Directive and Physician Ownership and I was offered and;

\_\_\_\_\_ I **received** a copy of the Patient Bill of Rights, Advance  
INITIAL Directive and Physician Ownership

\_\_\_\_\_ I **declined** a personal copy of the Patient Bill of Rights, Advance  
INITIAL Directive and Physician Ownership

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our office and copies are available at any time.

### Communication of Protected Health Information

**For Biopsy and / or Medical Results:** My preferred method of contact is (please choose all that apply):

- Email to this address (non-encrypted): \_\_\_\_\_
- Voice mail message at this phone number: \_\_\_\_\_
- Written letter to my mailing address on file: \_\_\_\_\_

**For Financial Information:** You may contact me at this phone number: \_\_\_\_\_

You may leave a message at the phone number listed above: [ ] Yes [ ] No

### Authorization Form for Use & Disclosure of Protected Health Information

It has been explained to me that disclosures of Personal Health Information (PHI) may be made to family and friends in accordance with my instructions below. It has also been explained that only information relevant to current treatment will be disclosed.

Accordingly, I authorize the disclosure of health care information to (list all that apply):

| Name | Relationship | In Person | By Phone | OK to leave Message | Phone Number |
|------|--------------|-----------|----------|---------------------|--------------|
|      |              |           |          |                     |              |
|      |              |           |          |                     |              |

I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that scanned document is the same as the original.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Signature

\_\_\_\_\_  
Relationship to Patient

### Medical History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Accompanied by: \_\_\_\_\_

Consult requested by:  Dr. \_\_\_\_\_ Referred by:  Self  Friend \_\_\_\_\_

Reason for today's visit:  Mohs  Skin Cancer Monitoring  Suspicious Lesion  Other \_\_\_\_\_

History of today's problem(s) only:  No problem today  Problems today are listed below

|                         | Problem # 1 | Problem # 2 | Problem # 3 |
|-------------------------|-------------|-------------|-------------|
| Skin areas involved:    |             |             |             |
| How long present?       |             |             |             |
| Previously biopsied?    |             |             |             |
| Treatment? (When/Type): |             |             |             |

Check all that apply to today's problem(s):  Not Applicable

|  |
|--|
| <b>Associated Symptoms</b>   |
| <input type="checkbox"/> Bleeding <input type="checkbox"/> Tingling <input type="checkbox"/> Itching <input type="checkbox"/> Scaly <input type="checkbox"/> Pain/sore/tender <input type="checkbox"/> Burning<br><input type="checkbox"/> Spreading <input type="checkbox"/> Redness <input type="checkbox"/> Other <input type="checkbox"/> None |

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Past Medical History** (Check all that apply and add any other important problems)

- None  High Blood Pressure  Diabetes  Pregnant  Breastfeeding
- Heart Disease  HIV/AIDS  Depression  Anxiety Attacks  Heart Valve Dysfunction
- Hepatitis B  Stroke  Faints Easily  RA/Lupus  Tuberculosis
- Hepatitis C  Renal Failure  Pacemaker  Hepatitis/Cirrhosis  Leukemia/Lymphoma
- Platelet dysfunction  Artificial Joint  Blood Transfusions  Organ Transplant  Myelodysplastic Synd.
- Cancer  Radiation Therapy  Dementia  High Cholesterol  History of MRSA/Staph
- Abnormal Scarring/Keloids  Needs Antibiotics prior to Dental Procedure  Implantable Neurological Device

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

Previous Skin Cancer:  No  Yes, please list location, date and treatments: \_\_\_\_\_

Other Major Illnesses, Surgeries, Hospitalizations  No  Yes, please list: \_\_\_\_\_

Family history of skin cancer?  None  Basal Cell  Squamous Cell  Melanoma

What is your occupation? \_\_\_\_\_ Is English your main language? [ ] Yes [ ] No \_\_\_\_\_

Do you have any problems with mobility? [ ] No [ ] Yes \_\_\_\_\_

Do you have religious, cultural, spiritual practices that might affect how we treat you? [ ] No [ ] Yes \_\_\_\_\_

Do you have any problems with your vision or hearing that might affect how we treat you? [ ] No [ ] Yes \_\_\_\_\_

Smoking/Tobacco Status (this includes all forms of tobacco products)

- Current- Year started \_\_\_\_\_
- Former- Year started \_\_\_\_\_ Year stopped \_\_\_\_\_
- Type of tobacco product \_\_\_\_\_
- Never

Alcohol Status

How many times in the last year have you had 5 or more drinks in one sitting? \_\_\_\_\_

Flu Vaccine

- Previously immunized- date (include month and year) \_\_\_\_\_
- Not immunized

Pneumonia Vaccine

- Previously immunized- date (include month and year) \_\_\_\_\_
- Not immunized

**Patient Medication Information**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**\*\*Required Pharmacy Information:**

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Are you **allergic** to any medications?

[ ] No, I have no known allergies to medication [ ] Yes, I have an allergy to the medication(s) listed below:

Medication: \_\_\_\_\_ Medication: \_\_\_\_\_

Medication: \_\_\_\_\_ Medication: \_\_\_\_\_

**Please list all medications that you are currently taking:**

**Prescribed and Over the counter medications**

Please include dosage and how often you take them

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
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## Financial Policy

### IDENTIFICATION REQUIREMENTS

This Practice is committed to safeguarding your identity. Federal regulations require verification of your identity at each visit to verify the identity of anyone presenting medical insurance identification. To satisfy the federal requirements, your driver's license will be scanned into your electronic file. This allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent your being seen by our physician.

### ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, for services provided under their care.

### HEALTH INSURANCE ELIGIBILITY, POLICY UPDATES & NEW INSURANCE

It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit. In your agreement with your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. It is your responsibility to understand your benefit plan. All prior balances must be paid prior to your visit. We DO NOT participate with all insurances. If we do not accept your insurance, and you wish to be seen at our office, you may elect to pay for services in accordance with the FINANCIAL RESPONSIBILITY listed below. It is important to note that any money paid on your self-pay account will not be applied to your insurance deductible. Failure to provide accurate insurance information, which causes denial of your services, may lead to dismissal from the Practice.

### REFERRALS & AUTHORIZATIONS

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to reschedule. It is also my responsibility to ascertain if a pre-authorization is required by my insurance company. The billing department will obtain the pre-authorization for me once notified. PLEASE NOTE: When calling your insurance company to find out if a pre-authorization is required for the MOHS procedure, you will want to tell them you are having the procedure done at Christine Rausch, MD, PC, NOT Skin Surgery Center of Virginia, LLC.

### BILLING INFORMATION

When a surgery or procedure is performed in the Ambulatory Surgery Center (Skin Surgery Center of Virginia, LLC), you may receive TWO (2) SEPARATE BILLS; one (1) from the physician (Christine S. Rausch MD, PC) and one (1) from the Ambulatory Surgery Center. The physician's bill will include all services rendered in the office AND for the physician's treatment in the Ambulatory Surgery Center. The Ambulatory Surgery Center bill is the fee for the use of the Medicare-certified and Joint Commission accredited facility.

### PATHOLOGY & LAB SERVICES

Some services, such as blood work and tissue obtained from biopsies or surgical specimens, require an outside laboratory for processing and evaluation. Billing for these services will be directly handled by these outside laboratories. While we do attempt to route specimens to the proper lab based on your insurance, we cannot guarantee their participation. By signing, you are giving us permission to provide your insurance information to the lab on your behalf. It is your responsibility to provide accurate and correct insurance information.

### ABN (*Advanced Beneficiary Notice*)

The Federal Medicare program, administered through the Center for Medicare and Medicaid Services (CMS), does not cover many services they consider medically unnecessary or inappropriate. You're responsible for all fees related to these services. You'll be notified, and your signature will be required prior to receiving any potentially uncovered services. Supplemental or secondary insurance to Medicare will not cover services denied by Medicare. Please check with your insurance carrier prior to treatment if you're concerned about these issues.

### **MISSED & CANCELLED APPOINTMENTS**

We require at least 48 business hours' notice if you must cancel an appointment. Failure to do so will result in the following cancellation fees: **\$100.00 for surgical appointments and \$50.00 for office visits**. The office is open Monday through Friday. Missed appointments will require a \$50 deposit prior to rescheduling.

### **LATE FOR APPOINTMENT**

**If you arrive 15 minutes late or more to your appointment, you will likely be asked to reschedule unless the physician's schedule can accommodate you.**

**This does not mean you will be seen immediately, but we will try to work you in between the other scheduled patients.**

### **COSMETIC PROCEDURE**

Patients are expected to pay in full at the time of service. All cosmetic procedure fee(s) will be collected in full at the time of service.

### **COLLECTION OF CO-PAYS & DEDUCTIBLES**

Per your agreement with your insurance carrier, you are required to pay all applicable co-payments at the time of service. In addition, if you are insured with a high-deductible insurance plan and have not met your deductible, we may collect the contracted rate for services rendered at the time of service.

### **RETURNED CHECKS**

Checks are processed by a third-party vendor. The vendor will directly bill you \$35.00 for any check that is returned for insufficient funds.

### **FINANCIAL RESPONSIBILITY**

I understand that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, as a courtesy, will file my insurance claims with insurance companies that the Practice participates with; however, I am ultimately responsible for the full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party understands that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for service rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees, including the total unpaid balance due, plus court costs and filing fees incurred by Christine S. Rausch, MD, PC / Skin Surgery Center of Virginia, LLC.

I understand and agree that should Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 ½%) per month, eighteen (18%) per annum, beginning on the date of judgment.

All patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits. Your remittance is due within ten business days of receipt of your bill. Payment plans are accepted for a six (6) month period, beginning on the first date of service with a balance. If previous arrangements have not been made with our billing department, any account balance outstanding longer than 90 days will be forwarded to a collection agency. Any patient account balance over 90 days past due that does not have a financial payment contract or a credit card on file will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their financial payment contract.

### **CONSENT FOR THE RELEASE OF MEDICAL RECORDS OR CANCER CLAIM FORMS**

I authorize Christine S. Rausch, MD, PC / Skin Surgery Center of Virginia, LLC, to release necessary medical information to my insurance company, its agents, or any third-party payer in order for payable benefits for these services to be determined. Medical record requests are free for pages 1 – 50. If your request is greater than 50 pages, there will be a fee of \$0.25 per page up to a maximum of \$15.00. Third-party requests (i.e., attorney, life insurance, disability, etc.) will incur a retrieval fee, \$0.25 per page fee, and postage fee. A separate CONSENT FOR THE RELEASE OF MEDICAL RECORDS Form must be completed before your request can be processed.

If you would like the office to complete Cancer Claim Forms, there will be a flat administrative fee of \$10.00 per Cancer Claim Form.

All Records/Forms must be picked up or emailed; we do not mail them.

### CREDIT CARD PAYMENTS

The Practice requires you to have a credit/debit card on file, along with a valid email address, at the time of check-in. We have partnered with Elavon, an electronic payment processor that encrypts and stores your information, providing the highest level of payment security and giving you the peace of mind that your payment for health care services will be handled securely, accurately, and on time. It protects your credit score by avoiding billing mistakes that can easily happen when billing and payments are handled using a manual process.

After your health insurance company processes your claim, you will receive an Explanation of Benefits, which is also sent to us. Your payment responsibility will be charged to your credit/debit card. If you feel an error has been made, call us, and we can stop processing the charge while we investigate. **Refusal to put a card on file requires a \$1500 deposit for Mohs Surgery—a \$500 deposit for procedures, and a \$100 deposit for office visits (inclusive of co-pay).**

On the day of surgery, a \$500 deposit will be collected from those patients with Medicare as their primary insurance, and no secondary insurance is available. Patients with no health insurance will be considered "self-pay,"; requiring a **\$1500 deposit for Mohs Surgery, a \$500 deposit for procedures, and a \$150 deposit for office visits.** We accept Visa, MasterCard, and Discover.

### OVERPAYMENTS/REFUNDS

Once ALL insurance payments have been received and it is deemed you have made an overpayment, we will refund the overpayment to you promptly. All credit balances less than \$5.00 (five dollars) can be donated to Access Now, a program administered by the Richmond Academy of Medicine that provides FREE medical care to qualified individuals in the Richmond area. Please indicate if you would like to donate your refund.

- Yes, please DONATE my refund of \$5.00 or less to ACCESS NOW.
- No, I do not wish to donate my refund of \$5.00 and would like the funds returned to me.

I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, will scan this document and destroy the original, and I agree that the scanned document is the same as the original.

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Signature of Patient or Responsible Party

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Date

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Printed Name of Signature

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Relationship to Patient

## William F. Schleicher, M.S., M.D.



Dr. Schleicher is a specialist in cosmetic, plastic and reconstructive surgery. He completed his undergraduate studies at the Virginia Polytechnic Institute and State University in Richmond, Virginia. He received his Master of Science degree

in Physiology from the Virginia Commonwealth University Health System. He received his Doctor of Medicine degree from the Virginia Commonwealth University Health System where he also completed his internship and residency training in plastic and reconstructive surgery. Dr. Schleicher completed his Fellowship in Aesthetic surgery at the Cleveland Clinic in Cleveland, Ohio.

Joining Dr. Schleicher's expertise in reconstructive and aesthetic plastic surgery with Dr. Rausch's expertise in Mohs skin cancer care and reconstruction represents a dual-specialty practice model. With a focus on optimizing the patient experience, our physicians provide comprehensive skin cancer care and aesthetic and reconstructive surgery in one convenient location. Dr. Schleicher will also offer a full line of cosmetic plastic surgery of the face, breast and body.

Dr. Schleicher is a licensed physician in the Commonwealth of Virginia, board certified by the American Board of Plastic Surgery, and an active member of the American Society of Plastic Surgeons.

**Dr. Schleicher is committed to using his surgical expertise to provide patients superior cosmetic results during Mohs surgery closures and the reconstruction process.**

## Facility & Staff

Our facility is specifically designed for the treatment of skin cancer. The Skin Surgery Center of Virginia conforms to and is approved by the State of Virginia, Medicare and Joint Commission standards in design, policies and procedures, fire protection, safety and handicap accessibility. These standards are considered to be the highest and ensure the safest surgical environment, while performing surgery in a comfortable, cost-effective, outpatient setting. Our procedure and exam rooms have state-of-the-art lighting for better detection of skin cancer and visualization of the cancer's outer margins.

We take great pride in our staff's training and capabilities. The team consists of the physicians, nurse practitioner, registered nurses, licensed practical nurses, medical assistants and patient care coordinators.

## Insurance & Referrals

We participate with most insurance plans and will submit all claims to your insurance company. Fees for expenses not covered (cosmetic procedures, co-pays, deductibles, co-insurance, some office visits) will be collected at time of service. We accept cash, check or credit cards.

Please check with your insurance company before surgery about pre-authorization, out of pocket expenses or if a referral is required. Please give them the correct code information for your referral. You are having Mohs surgery (procedure code 17311) for skin cancer (diagnosis code C44.90). Your surgery is an outpatient procedure performed in our Ambulatory Surgery Center. **You/your insurance company could receive up to three separate bills from the physician(s) and the Ambulatory Surgery Center when utilized.**

Our goal is to provide care to patients, regardless of financial status. If you have difficulties paying your bill or need help understanding your bill, please contact our office at 804.282.4940 and press 2 for billing.



## Mohs Surgery

Appointment Date

Appointment Time

### Important Reminders

**Expect to be here all day and to identify your biopsy site.**

Make arrangements for someone to drive you.

Do not plan surgery around an important engagement.

Do not travel outside of the area for 1 week after surgery.

Plan to return 1 week after surgery.

Continue all medications prescribed by your doctor except narcotics and benzodiazepines.

Fee charged for cancellations within 48 business hours of appointment.

Verify medical insurance coverage and the need for a referral, pre-authorization, co-pay and deductibles.

### Christine S. Rausch, MD, PC

*Skin Cancer Specialist & Mohs Micrographic Surgeon*

### William F. Schleicher, MS, MD

*Plastic & Reconstructive Surgeon*

Gaskins Professional Office Park  
2510 Gaskins Road · Henrico, VA 23238  
804.282.4940

[www.mohsvirginia.com](http://www.mohsvirginia.com)

## Christine S. Rausch, M.D.

Dr. Rausch is a specialist in skin cancer, Mohs micrographic surgery and reconstructive surgery. She graduated Summa Cum Laude and Phi Beta Kappa from the University of Richmond. Dr. Rausch received her Doctor of Medicine degree from Eastern



Virginia Medical School where she graduated as one of the top students in her class and was elected to the Alpha Omega Alpha Medical Honor Society early in her junior year. She received her Internal Medicine and Dermatology training at the University of Pittsburgh Medical Center. Following her residency, Dr. Rausch completed her fellowship training in Mohs Micrographic Surgery at Geisinger Medical Center. She is a Mohs College graduate, having completed the extra one-year fellowship training program in skin cancer surgery, pathology and advanced reconstructive surgery.

Dr. Rausch possesses the skills and experience necessary to perform Mohs micrographic surgery and reconstruction at all levels of complexity. Dr. Rausch is a licensed physician in the Commonwealth of Virginia and an Assistant Clinical Professor in the Department of Dermatology at Virginia Commonwealth University School of Medicine. She is board certified by the American Board of Dermatology, an active member of the American Academy of Dermatology and a fellow of the American College of Mohs Micrographic Surgery and Cutaneous Oncology.

**Dr. Rausch is strongly committed to patient care and the treatment of skin cancer with a focus on achieving superior cosmetic outcomes.**

We're pleased you have chosen our office for your surgical care. It's essential that our patients are well informed, relaxed, happy and above all, confident with our care. This brochure will help you understand how our facility works, answer questions and prepare you for surgery. Please feel free to ask any questions regarding your medical care, fees, insurance, or office policies. We welcome suggestions that will help to improve the care you receive.

## Mohs Micrographic Surgery

**What is Mohs surgery?** Mohs micrographic surgery is a safe and highly effective technique whereby skin cancers are removed under complete microscopic control. In Mohs surgery, a layer of skin is removed around the visible cancer. Detailed maps are then drawn of the area, and 100% of the tissue margin is examined under the microscope to be sure all of the cancer and its roots are gone. If any cancer remains, that exact area of involvement is sampled, and the entire process is repeated until the cancer is totally eradicated.

**Why do I need Mohs surgery when it seems the biopsy removed all the cancer?** Cancers grow on top of skin but also have roots deep within the skin. A biopsy only samples the top portion of the cancer. If the roots are not removed, the cancer will continue to grow.

**What are the advantages of Mohs surgery?** By using the mapping technique and complete microscopic control, the Mohs surgeon can pinpoint areas involved with cancer that are otherwise invisible to the naked eye. Therefore, even the smallest microscopic roots of a cancer can be removed. Benefits include the ability to save as much normal skin as possible and the highest possibility for curing the cancer. In contrast, standard surgery techniques look at <1% of the margins, providing only an estimate of whether the margins are clear. Also, with standard surgery, the slides are not examined the same day, allowing the chance of finding a positive margin at an outside pathology lab and having to perform additional surgery at a later time to clear the margin.

**What are the chances for a cure?** Mohs surgery offers a greater than 99% cure rate for the majority of skin cancers and 95% when previous forms of treatment have failed or the cancer has recurred. Cure rates for other treatment methods are significantly lower than Mohs surgery.

## Day of Surgery

Please arrive at our office at the specific time assigned to you. This is a surgical appointment and differs from a regular office visit. Your actual surgery time will be **roughly one hour after you arrive**, as the physician needs to thoroughly

review your case and your surgical suite needs to be prepped.

Once the preparation is complete, our doctors will discuss your case and further explain the procedure. A local anesthetic is injected into the skin. Once the area is numb, the cancer and a layer of tissue around it is removed. This part of the procedure takes 10 to 15 minutes. A temporary dressing is applied and you'll be escorted to our waiting area. While you wait, the tissue is taken to our lab to be mapped, color coded, processed and examined under the microscope by Dr. Rausch. This part of the procedure takes a minimum of two hours. If any additional affected area is identified, the process is repeated until all of the cancer is removed. The number of stages or layers required depends on the size and depth of the tumor. **Since we cannot predict in advance the number of stages necessary to fully remove the tumor, you should plan on spending the whole day with us.**

It's important to realize that Mohs surgery involves cutting the skin, not just scraping. One is left with a hole after the tumor is removed. Options for repair are difficult to determine before surgery since one can not predict the final defect. However, once the area is cancer free, Dr. Rausch and Dr. Schleicher will discuss the options for wound healing and surgical repair of the defect. They include letting the wound heal by itself, closing the wound in a side-to-side fashion with stitches, or closing the wound with a skin flap or graft. **Repairing locations on the nose, ear, eyelid or lip can often be more involved than anticipated because these locations do not have tissue that can be brought together easily.** Filling the hole can be more of a challenge, often requiring a flap or graft. Following the repair, a dressing is applied and you will be given instructions on wound care and dressing changes. Occasionally, if warranted, other surgical specialties may be utilized for their unique skills.

## Preparing for Your Surgery

**Pre-operative Consultations** are done the day of surgery but can be arranged prior to surgery if desired. If you're uncertain about surgery because you are considering another form of treatment or no treatment at all, please call **before** your scheduled surgery date to avoid a cancellation fee.

**Biopsy Site Identification:** Smaller cancers are difficult to identify. You **must** be able to identify your biopsy site the day of surgery. It's helpful to take a photo of your biopsy site before it heals. Bring the photo with you the day of surgery or email it to

[info@mohsvirginia.com](mailto:info@mohsvirginia.com) (photos you send may not be encrypted).

**Medications:** Continue all medications, except narcotics and benzodiazepines, prescribed by your doctor, including blood thinners, aspirin, Coumadin, Plavix, Vitamin E and blood pressure medications. Studies show discontinuation of prescribed medications, even for short periods, can put one at risk for life threatening events, such as heart attack and stroke.

Do NOT take any benzodiazepines- Diazepam (Valium), Lorazepam (Ativan), Alprazolam (Xanax), Clonazepam (Klonopin), Temazepam (Restoril), Chlordiazepoxide (Librium), Clorazepate (Tranxene), Oxazepam (Serax), or narcotics- Codeine, Fentanyl, Hydrocodone, Lortab, Norco, Vicodin, Hydromorphone (Dilaudid), Demerol, Methadone, Morphine, Oxycodone, OxyContin, or Percocet the day of your surgery. Identification of the site and signing of the consent form need to be done PRIOR to taking any of these medications. Bring your medication with you the day of surgery, and it can be taken after signing the consent. If any of these medications are taken prior to signing the consent, surgery will be canceled and a cancellation fee will apply.

**Food and Drink:** Since surgery is performed under local anesthesia, you may eat and drink that day. We recommend bringing a lunch with you. Our coffee bar has a refrigerator and microwave available. You'll be asked to remain in the office during the procedure, but your companion can visit one of the eateries located near our office and bring you back food.

**Alcohol** promotes bleeding. We ask you to avoid alcoholic beverages 48 hours before/after surgery.

**Smoking** can affect healing by diminishing blood supply at your surgery site. Discontinue smoking 2 days before surgery and for 1 week after surgery. If you can't discontinue entirely, cut back to less than 1 pack per day.

**Transportation:** Make arrangements for someone to drive you the day of surgery. Patients given medicine to relieve anxiety will not be allowed to drive themselves home.

**Attire:** Wear comfortable, older clothes, avoid make-up, perfume and jewelry. If surgery is on an area covered by clothing, wear something easy to remove.

**Passing Time:** Bring reading material or your computer to occupy time while waiting for the microscope slides to be examined. Wireless internet access is available.

**Cancellations:** If you must cancel surgery, please cancel 48 business hours before your surgery date. Less than 48 business hours notice will result in a cancellation fee.

## After Surgery

Please do not travel outside the area for 1 week so that any unforeseen post-operative events can be addressed in office. If you have any problems at home after surgery, please call our office. Verbal and written instructions for wound care will be given to you at the end of your day.

**Will I have pain and bruising after surgery?** The surgical site may be sore for several days. Tylenol and Ibuprofen are usually adequate for relief. Bruising and swelling are common and may not peak until 48 hours after surgery. Do not plan surgery around an event where your physical appearance is important as you'll be wearing a bandage for a week in most cases.

**Will I be able to return to work or be able to drive?** If you're given medications during surgery, you will not be allowed to drive yourself home. Returning to work or driving will depend on the size and location of your cancer/abnormal lesion and your occupation. Please bring all FMLA paperwork with you the day of surgery. In most cases, time off work will not be granted after surgery. Specific restrictions will be discussed the day of surgery. If you would like to discuss this prior to surgery so arrangements can be made ahead of time, a consult is required.

**Can I exercise after surgery?** Activities, including exercise or heavy lifting, will be restricted until stitches are removed. The more activity you participate in, the more likely you may bleed from the surgery site.

**Will the surgery leave a scar?** Whenever surgery is performed, there will be a scar. Dr. Rausch and Dr. Schleicher are trained in advanced reconstruction and fine suturing techniques to optimize the cosmetic outcome.

**Will I need to come back?** Suture removal and wound evaluation are usually performed one week after reconstructive surgery, which will not be done until the pathologist determines that all the cancer is removed. In some cases, additional visits may be needed over the next several weeks to months. Periodic visits, at least once a year, to your referring physician are advisable to monitor for skin cancers or signs of recurrence.