SUMMER CLARK M.D.
1611 Wallace Blvd.
AMARILLO, TX 79106
(806)354-4900

Patient's Full Name:_____ Name Preferred to be Called:_____ Sex: _____
Street Address:_____ Race:_____
City:_____ State: _____Zip:_____ Home Ph: (____)_____ Cell Ph: ____)_____
Birth Date: _____ Age: _____ Social Security No: _____
E-Mail Address:_____

Marital Status: (circle) M S W D Spouse's Name:_____
Spouse's Social Security No: _____ Spouse's Birth Date:_____
E-Mail Address_____

Responsible Party (if different than patient or spouse):_____
Address:_____ City/State/Zip:_____
Social Security No:_____ Birth Date:_____ Relationship to patient:_____
Responsible Party Home Ph: (____)_____ Cell Ph: (____)_____

If Referred by Another Physician – Physician Name:_____
Address:_____City/State/Zip:_____
Phone: (____)_____ Primary Care Physician (if different from referring Physician):_____
Address:_____City/State/Zip:_____
Phone #_____

Primary Insurance Company
Name:_____
Address:_____
City/State/Zip:_____
ID Number:_____
Subscriber Name:_____
Subscriber Social Security No:_____
Subscriber DOB:_____

Secondary Insurance Company
Name:_____
Address:_____
City/State/Zip:_____
ID Number:_____
Subscriber:_____
Subscriber Social Security No:_____
Subscriber DOB:_____

Patient's Employer: _____ (Full time____) (Part time____) (Retired____)
Address:_____ City/State/Zip:_____
Work Ph: (____)_____

Spouse's (or Responsible Party's) Employer (or retired from):_____
Address:_____City/State/Zip:_____
Work Ph: (____)_____

Emergency Contact:_____ Relationship:_____
Address:_____ City/State/Zip:_____
Phone: (____)_____ Cell Ph: (____)_____

I authorize the release of any medical information by Proffer Surgical Associates LLP for any insurance claims submission and at the doctor's discretion, assign the insurance payment to them for these services. I understand that I am financially responsible for the charges that are not covered.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____DATE: _____

MEDICAL HISTORY

Personal Medical History: Have you ever had or do you now have: (Check YES or NO)

	YES	NO		YES	NO
1. SHORTNESS OF BREATH			11. DIABETES		
2. CHEST OR HEART PAIN/ANGINA			12. SKIN PROBLEMS		
3. HEART DISEASE OR ATTACK			13. ARTHRITIS/JOINT PROBLEMS		
4. HIGH BLOOD PRESSURE			14. THYROID DISEASE		
5. HEART VALVE PROBS/MURMURS			15. HEPATITIS/JAUNDICE/LIVER TRB.		
6. EASY BRUISING			16. CANCER/TUMOR (OTHER THAN SKIN CANCER)		
7. EXCESSIVE BLEEDING			17. AIDS OR HIV		
8. ANEMIA OR BLOOD DISEASE			18. BLOOD CLOTS		
9. DO YOU USE BLOOD THINNERS? IF YES, NAME & DOSE			19. ANESTHESIA PROBLEMS		
10. DO YOU HAVE AN IMPLANTABLE DEFIBRILLATOR?			20. DO YOU HAVE A PACEMAKER?		
			21. DO YOU TAKE ANTIBIOTICS PRIOR TO ANY DENTAL PROCEDURES?		

Have you had a pneumonia vaccination? _____ yes _____ no. If yes, what was the date: _____

Have you had a flu vaccination? _____ yes _____ no. If yes, what was the date: _____

List Surgeries AND Dates:_____

Cardiologist Name:_____ Primary Care Physician:_____

Do you have a pacemaker or defibrillator? _____

Do you have cardiac stents? Yes □ No □

SKIN CANCER HISTORY

Basal Cell Carcinoma Yes □ No □ / Squamous Cell Carcinoma Yes □ No □ / Melanoma Yes □ No □ / Other Yes □ No □

Have you ever been treated with Mohs Surgery? Yes □ No □

Do you have a history of abnormal scarring? Yes □ No □

SMOKING HISTORY

Do you smoke/vape Yes □ No □

If so, how long have you Smoked/Vaped?_____

If so, how many pack/day? _____

If quit, how long ago? _____

ALCOHOL SCREENING:

Did you have a drink containing alcohol in the past year? Yes □ No □

If yes -

How often did you have six or more drinks on one occasion in the past year? _____

How many drinks did you have on a typical day when you were drinking in the past year? _____

How often did you have a drink containing alcohol in the past year? _____

Do you take illicit drugs: Yes □ No □

FAMILY HISTORY: If any blood relatives has suffered any of the following – please indicate which relative.

Bleeding Problems _____ Heart Disease _____

Melanoma _____ Anesthesia Problems _____

Diabetes _____ Other _____

COMMENTS (Please let us know if you suspect pregnancy during any part of our treatment)

_____

_____

PREFERRED PHARMACY: _____ PHONE NUMBER: _____

Patient Signature_____ Date _____

Patient Name: _____ Date: _____

Please list ALL drug allergies and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the-counter medications taken:

Medication	Dosage	Frequency Taken

Continue on back if needed

Patient Name: _____ Date: _____

Please list ALL drug allergies and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the-counter medications taken:

Medication	Dosage	Frequency Taken

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, the undersigned patient consent to the following, photographs and/or videos of me to be used by Proffer Surgical Associates.

I consent to such photographs, videos and any associated quotes by me being edited and published by my Doctor and/or any party acting under my Doctor's license and authority in any print or electronic form, including, but not limited to posts on social media, for the purpose of informing the medical profession or the general public about aesthetic procedure methods and results, surgical and non-surgical, and whether or not such settings are regarded as educational, scientific of commercial.

I expect to be recognized from my likeness or quotes.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photographs, videos or quotes and from my claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these material in any medium. I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient Signature Witness / Physician

_____ _____

Printed Patient Name Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____

Patient/Guardian/Conservator Signature Date

_____

Printed Patient/Guardian/Conservator Name

Proffer Surgical Associates

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

I _____ have received a copy of this office's Notice of Privacy Practices. *You have the right to refuse to sign this document*

_____

(Please Print Name)

_____

(Signature)

Date: _____

I give permission to release medical information to the following persons:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ The patient or individual refused to sign this document

_____ Communications conflicts prohibited us from obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify) _____

_____

PROFFER
SURGICAL ASSOCIATES

Marketing Authorization Form

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:
   a. Receive treatment communications concerning treatment alternatives or other health related products or services.
   b. Be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may interest me.

- **I understand that I have the right to "opt out" of receiving such communications.**
- **I understand that this practice may receive remuneration for communications.**

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:

□ **I wish to receive Marketing Communications from this Practice Only.**
□ **I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.**
□ **I do <u>NOT</u> wish to receive any Marketing Communications.**

Patient Signature: _____

Communication that encourages you to use our services is considered marketing. If we intend to use, or sell PHI for personal gain or commercial advantage, we must **first obtain written authorization.** Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications for a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. **We MAY receive financial remuneration from a third party due to marketing.**

HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications.

In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.

PROFFER
SURGICAL ASSOCIATES

Liana H. Proffer, MD, FAAD
Surgical Dermatology
Skin Cancer Surgery
Mohs Micrographic Surgery
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Fellow of American College
Of Surgeons
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You are scheduled to have Mohs surgery (skin cancer removal) by Dr. Liana Proffer or Dr. Summer Clark. We value you as a patient and want your experience in our office to be as comfortable as possible. We strive to give each patient the individual attention they deserve.

The skin cancer will be removed in stages to allow for complete removal, while sparing as much normal surrounding skin as possible. It is often impossible to predict the number of stages, and thus the amount of tissue that will need to be removed. Once the cancer is surgically removed, many patients can be reconstructed in the office. However, if your reconstructive procedure is more complex, it may be necessary for surgical repair to be performed in the operating room in our ambulatory surgery center (ASC).

By law, the ASC is a separate and distinct facility, even though it is attached to our office. Your insurance may require a separate charge or co-pay for the ASC.

It is always our goal to perform your reconstruction the same day as the skin cancer removal. However, occasionally reconstruction may need to be scheduled on a separate date if the Mohs procedure is prolonged or if the operating room is required but unavailable.

We pride ourselves on having a highly skilled team of our surgeons in our office, each with their own areas of expertise. On occasion, you may be referred to one of these specialists for reconstruction if it is felt by Dr. Proffer or Dr. Clark to be in your best interest.

All of this will be reviewed when you come for your procedure.

Sincerely,

Dr Liana Proffer Dr Summer Clark

MOHS
MICROGRAPHIC SURGERY

Proffer Surgical Associates
Summer Clark, MD
Dual Board-Certified and Fellowship-Trained
Dermatology and Mohs Micrographic Surgery
806-354-4900

ABOUT SKIN CANCER

Skin cancer is by far the most common malignant cancer in humans. The most common types of skin cancer are Basal Cell Carcinoma and Squamous Cell Carcinoma. Both Basal Cell Carcinoma and Squamous Cell Carcinoma begin as a single point in the upper layers of the skin and slowly enlarge, spreading both along the surface and downward. These extensions cannot always be seen directly. The tumor often extends far beyond what is visible on the surface of the skin. If not completely removed, both types of skin cancer can invade and destroy structures in their path.

Excessive exposure to sunlight is the single most important factor associated with the development of skin cancers. In addition, the tendency to develop these cancers appears to the hereditary in certain people, especially those with fair complexion. Fair-skinned people develop skin cancers more frequently and the more sun exposure they receive, the more likely they are to develop a skin cancer

MOHS MICROGRAPHIC SURGERY

Mohs Micrographic Surgery allows the selective removal of areas involved with skin cancer while preserving as much of the surrounding normal tissue as possible.

Because of the complete systematic microscopic search for the "roots" of the skin cancer, Mohs Micrographic Surgery offers a 97-99% chance for the complete removal of a skin cancer which has not had prior treatment, without an excessive loss of normal tissue.

The chance for complete removal of tumors which have returned after other therapies is still excellent, but slightly lower. As a result, Mohs Micrographic Surgery is very useful for large skin cancers, those with indistinct borders or near vital functional or cosmetic structures, and tumors for which other forms of therapy have failed. However, no surgeon or technique can guarantee a 100% chance of cure.

After the visible portion of the tumor is removed by excision or curettage (debulking), there are two basic steps to each Mohs Micrographic Surgery stage. First, a thin layer of tissue is surgically removed from the base of the defect created by debulking. Next, this tissue is processed and examined under the microscope. On the microscopic slides, the physician examines the entire bottom surface and the outside edges of the removed tissue. If any tumor is seen during the microscopic examination its location is established, and a thin layer of additional tissue is excised from the involved area. The entire process is repeated until no tumor is seen on the microscopic examination.

BEFORE MOHS MICROGRAPHIC SURGERY

Be well rested and eat a good breakfast. Take your usual medications. Bathe as usual and shampoo your hair the night before surgery, as your wound and initial dressing have to remain dry for 24 hours after surgery.

The length of the surgery varies depending on the size and location of the skin cancer and the type of reconstruction to be done. Although the average length of time is approximately three to four hours, you should plan on spending most of the day. We ask you limit the number of people accompanying you to one or two persons because of the limited space in our waiting room.

THE SURGERY

Before the procedure begins, the doctor will again discuss the procedure with you and obtain your written consent for the procedure. If you have any questions, please feel free to ask them at this time. Once you are in the room, we will cleanse the area with a sterile antibacterial soap, and we will place several sterile drapes over you. We will anesthetize (numb) the area of the skin containing the cancer with a small local injection (needle). This injection will probably be similar to the one you received when your biopsy was taken. After the tissue has been removed, it will be processed in our laboratory next to the room you are in.

Depending upon the amount of tissue removed, processing usually takes about 45 minutes. You will either remain in the room or in our waiting room while the tissue is processed and examined by the doctor. If the microscopic examination of the removed tissue reveals the presence of additional cancer, we will go back and remove more tissue. Most skin cancers are removed in two or three surgical stages.

RECONSTRUCTION

After the skin cancer has been completely removed, a decision will be made on the best method for treating the wound created by the surgery. These methods include letting the wound heal by itself, closing the wound in a side-to-side fashion with stitches, and closing the wound with a skin graft or a flap. During the preoperative evaluation, the methods which might be appropriate to your case will be discussed with you; however, in most cases, the best method is determined on an individual basis after the removal of cancer is complete. We may complete your reconstruction, or other surgical specialists may be called on to use their unique skills. Occasionally, a tumor may turn out to be larger than was initially anticipated. When that happens, the required reconstruction may be more complex and extensive than initially anticipated.

If the reconstruction is complex, it may take place the same day or a few days later. If the reconstruction will be extensive, that portion of the operation may be performed in our surgical center.

AFTER MOHS MICROGRAPHIC SURGERY

Your surgical wound will require wound care during the weeks following surgery. Detailed written instructions will be provided after your surgery is completed. An emergency contact number will also be provided to you should you have problems, concerns, or urgent questions regarding your surgery. You should plan on wearing a bandage and avoiding strenuous physical activities for one-two weeks. Most patients report minimal pain which responds to Tylenol or Ibuprofen.

If sutures have been placed, they will either be dissolvable or not dissolvable. Non-dissolvable sutures will be removed one to two weeks after surgery. The surgical site may require observation during the first few months after surgery. We will schedule follow up visits in our clinic accordingly.

You may experience a sensation of tightness across the area of surgery. Skin cancers frequently involves nerves, and months may pass before your skin sensation returns to normal. In some cases, numbness may be permanent. You may also experience itching after your wound has healed. Complete healing of the surgical scar can take up to 12-18 months. Especially during the first few months, the site may feel "thick," swollen, or lumpy and there may be some redness.

Studies have shown that once you develop a skin cancer, there is a strong possibility that you will develop other skin cancers in the years ahead. If you notice any suspicious areas, please call your dermatologist if you have a dermatologist outside of Proffer Surgical Associates. If you do not have one, please call our office to schedule an appointment for evaluation.

Sunshine is not harmful to you as long as you use adequate protection. Fifteen to thirty minutes before sun exposure, you should liberally apply a sunscreen with a sun protection factor (SPF) of 50 or higher to all exposed areas. Since many sunscreens wash off with water or perspiration, reapply it after swimming or exercising. Also wear a broad-brimmed hat and use clothing to further protect yourself from the sun. Remember, sun exposure is most intense between 10AM and 3PM.

FINALLY

Mohs Surgery is an out-patient procedure. You will be awake for the entire time. Please ask your physician or nurse any questions you have about your surgery. We want you to be as comfortable, relaxed, and informed as possible.