



Dermatology & Allergy Specialists of Olympia, PLLC

Main Office: 304 West Bay Dr NW, Suite 301, Olympia, WA 98502

Voice: (360) 413-8760 Fax: (360) 413-8839

Mohs Surgery - 2nd Floor Suite 204: Dr. Jacob Bauer

Appointment Date: _____ Time: _____ **Check-in: 2nd Floor**

Thank you for choosing our Dermatology office! We look forward to making your visit as comfortable and productive as possible. The following steps will help us provide the best use of your time with the provider:

- ***Minor Patients: All minors must be accompanied by a parent/legal guardian at each visit. If not accompanied the appointment may be rescheduled.***
- ***Please arrive 15 minutes early so we can register/update your information.***
- ***Please provide ALL insurance cards, Picture ID, POA and/or current Provider One card if applicable:***
 - ***Current insurance card/s are required by your insurance company to be presented at every visit to our office. Your appointment will be rescheduled to the next available appointment if you do not present all insurance cards at registration.***
 - ***Your insurance company obligates us to maintain a copy of your insurance card in your medical record for the purpose of billing your visit.***
- Please refrain from wearing perfume or colognes to our office. Many of our patients have severe allergies, and as a courtesy to them our office is a "scent free" zone.
- Bring your referral, if required. Your insurance company can tell you if you need a referral; we are unable to contact them for you. If your insurance company requires a referral and one is not provided to us, your appointment will be rescheduled.
- Please be prepared to pay your co-pay at the time of check-in if one is required. We charge a \$10.00 fee to bill you later for co-pays.
- Please bring in the containers of any medications or over-the-counter products that you are using to treat the current problem.
- Please read entire packet and completely fill out any forms sent to you before arrival.
- ***Individuals seeking treatment are not considered to have been accepted into the practice and formed a provider-patient relationship until they have completed a face-to-face visit with a provider who has completed an evaluation and assessment.***

We recommend you allow plenty of time for your first appointment. This initial visit takes time to register, and we do not want to shorten your time with the provider or have to reschedule your appointment if you are late. Due to the shortage of dermatology providers, your appointment may have been scheduled some time ago, and it may not work with your current schedule. Please call us as soon as you are aware that you need to reschedule. With 48 hours notice, we are happy to reschedule; however the new time might be several weeks later. ***If you fail to keep your appointment without notifying us in advance, you will not be rescheduled again.***

Directions: Please see reverse side →

Office Hours: Monday, Tuesday, Wednesday 7:00 am - 4:30 pm / Thursday 9 am – 4:30 pm /
Friday 7:00 am - 4:00 pm
Appt Phones Open: Monday through Thursday 7:30 am – 4:30 pm / Friday 7:30 am – 4:00 pm

Directions to Dermatology & Allergy Specialists of Olympia

TRAVELING SOUTH on I-5, EXIT 105B:

Head west off Exit 105B, down ramp and travel 0.3 mi. Merge onto Plum St SE. Follow Plum St. to State Avenue, approximately 0.6 mi. Turn left onto State Ave NE and go 0.6 mi. Stay to the right and merge onto 4th Ave W and cross the bridge. At the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. Stay to the right and take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING NORTH on I-5, EXIT 103:

Head down the ramp to Deschutes Way SE and remain on this road as it becomes Deschutes Parkway SW. Continue on Deschutes Pkwy SW along the west side of Capital Lake for 1.8mi. Deschutes Pkwy turns into 5th Ave at the junction with the bridge. Travel for 0.1mi. Turn left on Simmons Street NW. Turn left onto 4th Ave W and cross the bridge. Merge into right lane and at the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. In the right lane take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING EAST on Highway 101:

Take the Black Lake Blvd exit toward W Olympia. At bottom of ramp turn left onto Black Lake Blvd SW, Travel 1.2mi. Turn right onto Harrison Ave NW and go approximately 0.6mi. As you head downhill, stay in left lane as you enter the traffic circle. Proceed around to the left, merge to the right and take the 2nd exit (right) onto W Bay Drive NW. The office will be one block down on the right.

Parking: During peak time, parking in Dermatology and Allergy's parking lot may be difficult. If space is available there is additional parking along the street on West Bay Drive.

***If you need help with parking or need assistance please call our appointment line at 360-413-8760**

Mohs Micrographic Surgery

Commonly Asked Questions

You have been referred to see Dr. Jacob Bauer, Dermatologic and Mohs Surgeon, of Dermatology and Allergy Specialists of Olympia for treatment of skin cancer. Below are some questions most frequently asked by our patients. Please take the time to read through them. We hope this information will acquaint you with the procedure and help put you at ease as you prepare for your visit. Please feel free to call with any questions or concerns.

What is Skin Cancer?



The most common skin cancers are known as basal cell and squamous cell carcinomas. There are over 1 million new skin cancers in this country each year. Fortunately, these two cancers rarely spread to other areas of the body and are rarely life-threatening. However, they can be locally aggressive, meaning they can infiltrate and destroy large areas of normal tissue.

Melanoma is the third most common type of skin cancer. Melanoma is completely curable if caught early. A modified Mohs Surgery is used only for particular types of melanoma.

What is Mohs Surgery?

Mohs Surgery is a specialized technique for removing certain types of skin cancers. Dr. Frederick Mohs began performing the procedure in the 1930s. The procedure has been continuously refined over the past 80 years and it is now an outpatient procedure performed with only local anesthesia.

After the tumor and surrounding skin has been completely numbed, the visible portion of the tumor is surgically removed. The tissue is then taken to our laboratory and processed where the physician uses a microscope to see if any cancer cells remain. If any cancer cells have been left behind, the surgeon will go back and remove additional tissue. This process is repeated as many times as necessary to ensure complete removal of the tumor. If no cancer cells are seen or once all cancer is removed, the surgeon will repair the wound with stitches (or allow the wound to heal if stitches are not needed).

What are the advantages of Mohs Surgery?



There are two primary advantages. First, by using the microscope to examine the tissue, the surgeon is better able to ensure that all cancer cells have been removed. In fact, *this procedure has the highest cure rate of all skin cancer treatments.* Second, because only cancerous tissue is removed, normal, healthy skin is preserved keeping the defect or

Jacob H. Bauer, M.D.



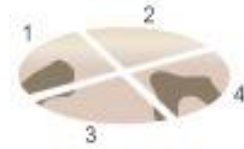
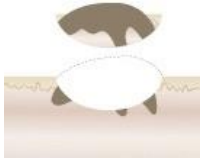
Dr. Bauer graduated from the University of Notre Dame and earned his medical degree from the University of Vermont College of Medicine in 2004. He completed his Dermatology residency at Geisinger Medical Center in Danville, PA followed by his Mohs Micrographic Surgery and Dermatologic Oncology Fellowship (Mohs surgery) at Brown University in Providence, RI in 2009 under the direction of Nathaniel Jellinek, M.D. and Raymond Dufresne, M.D., and is a Board Certified Dermatologist and Fellowship trained skin cancer and reconstructive surgeon. He is board certified in Micrographic Dermatologic Surgery and Dermatology by the American Board of Dermatology, and is both a member American College of Mohs Surgery and Cutaneous Oncology, and the American Academy of Dermatology.

The Mohs Surgery Laboratory Process

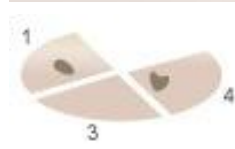
The skin cancer may extend beyond the visible margins. It is these extensions that lead to tumor recurrences after incomplete removal.



Mohs surgery first removes the visible tumor. Then a thin layer of tissue is removed, mapped and examined under the microscope



Additional layers are then removed precisely in areas of remaining tumor



This process is repeated, if needed, until all skin cancer is removed. Mohs surgery is the only method that examines the tissue edges so completely while preserving the maximum amount of normal tissue.



Additional questions

How long will the surgery last?

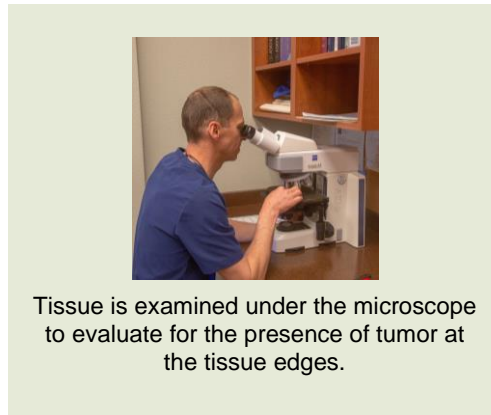
The length of the surgery depends on the extent of the skin cancer, but usually takes between 2 to 4 hours. Occasionally the visit is more lengthy, so we ask that you come prepared to spend the day. Much of your time will be spent waiting for the tissue to process in the lab. Bring reading material and whatever else will help keep you comfortable while you are with us.

Will I have stitches following the surgery?

Many wounds, but not all, do require stitches for optimal healing. Our goal is to give you the best functional and cosmetic result possible. Some wounds require more complicated procedures such as "flaps" or "grafts" while others do best if left to heal on their own. Your doctor will recommend the best option following removal of the tumor.

Will I have a scar after the surgery?

Unfortunately, there is no such thing as "scarless" surgery. However, we are trained in complex facial reconstruction. Our goal is to make your scar as undetectable as possible. The size of the scar often depends on the size of the tumor.



Will I be put to sleep for the surgery?

No. The surgery is well-tolerated with local anesthesia. Because the surgery may take several hours, the risk of prolonged general anesthesia is avoided.

Should I bring someone with me?

Yes. Surgery anywhere on the face can often lead to temporary swelling around the eyes potentially making it difficult to see. Additionally, a 24 hour pressure dressing will be placed over the surgical site which can sometimes make it difficult for glasses to rest properly. Out of concern for your safety, we ask that you bring a driver with you or make arrangements for someone to pick you up.

Should I take my regular medications on the morning of the surgery?

Yes. Take all your regular medications as they have been prescribed by your doctor unless we specifically tell you otherwise prior to surgery.

Should I eat before surgery?

Yes. Unless specifically told otherwise, you may eat a normal meal prior to surgery. It is also a good idea to bring snacks as you may be in the office for several hours.

Are there any medications I should discontinue prior to surgery?

Continue taking all your prescribed medications unless otherwise directed by us in advance. In general, we do not recommend that you stop taking any blood thinners such as Coumadin or Plavix. If there are special circumstances where these need to be stopped, we will notify you.

Will my activity be limited after surgery?

Yes. Physical activity, including sports and exercise, are often restricted following the surgery. If your job requires heavy lifting or physical exertion, you may need to plan to be off for a few days. Your doctor will give you specific instructions at the time of surgery.

Will I have much pain after the surgery?

Most people have surprisingly little pain after the surgery. Typically, the first 24 hours are the most uncomfortable. We recommend that you have extra strength Tylenol and ibuprofen available.



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PATIENT INFORMATION AND DEMOGRAPHICS FORM

MRN: _____

1) Patient's Last Name: _____ First Name: _____ MI: _____

Maiden or Alternate Name: _____ Gender: M / F / U

Marital Status: Single / Married / Divorced / Widowed / Legally Separated

Email: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

2) Mailing Address: _____ City: _____

(If mailing address is a **PO Box** please provide physical address for emergencies)

State: _____ Zip Code: _____

**Physical Address: _____ City: _____

(If same as mailing – write **SAA** (Same As Above))

State: _____ Zip code: _____

Home Phone #: _____ Cell Phone #: _____

3) Patient's Employer: _____ Student: Yes / No

Work Phone: _____ May we call you at work? Yes / No

4) Guarantor Information: Self / Parent / Spouse / Other: _____

(Please circle the one that applies)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ / _____ / _____ Gender: M / F / U

Mailing Address: _____ City: _____

State: _____ Zip: _____ Contact Phone #: _____

Employer: _____ Work Phone #: _____

Social Security #: _____ - _____ - _____

5) Who may we contact in case of emergency? Name: _____

Phone #: _____ Relation: _____

6) Primary Care or Referring Physician: _____ Phone #: _____

7) Do you have a Power of Attorney? Yes / No If YES, please provide a copy to our office.

Signature: _____ Date: _____



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Financial Policy and Assignment of Benefits

We would like to share our financial policies with you. The following outlines our mutual business responsibilities and allows us to provide quality, timely and complete health care.

PLEASE READ ALL INFORMATION CAREFULLY AND ACKNOWLEDGE BY INITIALING IN THE DESIGNATED AREAS. WHEN COMPLETED SIGNATURE IS NEEDED ON BACK PAGE.

Patient: _____

Date of Birth: _____ **Account #:** _____

Patient Responsibility, you agree to:

- Bring all your current insurance card(s) and picture ID to each visit. You are responsible to provide us with all current insurance information. Failure to provide us with the most current insurance information will result in all incurred charges being patient/legal guardian responsibility.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.
- Payment for any co-pays as well as any charges for non-covered services or any outstanding balances are expected to be paid at the time of your visit. Your co-payment will be collected at the time of service - no exceptions. We accept cash, checks, Visa, and Master Card.
- **Contact the Business Office prior to your visit if you have no insurance to make payment arrangements, we will ask that you pay a small deposit prior to being seen of \$100 for new patients and \$75 for established patients.**

I have read and understand the billing policy _____ (please initial)

- To cancel your appointment please call at least 2 business days in advance. Our business days are Monday through Friday. **We may charge a "missed appointment" fee for the following:**
 - **\$50 for Office Visits**
 - **\$100 for Procedures**

***Cancellations made after normal business hours may also be subject to cancellation fee**

I have read and understand the cancellation policy _____ (please initial)

- Notify us if any change of address, telephone numbers, employer or insurance.
- Patient to obtain any necessary referrals or authorizations prior to your visit, if your plan requires this to see a specialist.
- Angry or foul language directed at our staff is not tolerated and will be grounds for immediate dismissal from our practice.

Dermatology & Allergy Specialists Responsibility

SEE BACK PAGE →

- Commercial/Government Insurance Patients: If we participate with your plan, we will bill your insurance for you. If we do not participate with your insurance, as a courtesy we will file your claims. Understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement, unless other arrangements have been made.
- Medicare Insurance patients: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we may bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) may be collected at the time of service, along with charges for non-covered or cosmetic services (you will be asked to sign an Advance Beneficiary Notice form in the event that a service is provided for which we expect Medicare will not pay).
- Collections: We may assess a 1% monthly interest charge on unpaid balance over 60 days old. If we have not received payment in full after 90 days from the date of service, we may refer your account to an outside collection agency where you will be responsible to pay the costs of collection (including court costs and reasonable attorney fees). Any legal action shall be brought and maintained exclusively in a state court of Thurston County, State of Washington and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts. If your account is turned over to collections or you have an unpaid balance that is 90 days or older, you may no longer be able to be seen at Dermatology and Allergy Specialists of Olympia, PLLC. A fee of \$50 will be charged to any account with a check returned unpaid by the bank.

Remember whether you do or do not have insurance you are financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (360) 413-8408.

I authorize payment to be made directly to Dermatology and Allergy Specialists of Olympia. I understand any monies paid over and above my indebtedness will be refunded. I understand that whether I sign as patient or responsible party (e.g. parent, legal representative, guarantor), I am directly responsible and will pay for services rendered and not paid by my insurer, and that assignment of benefits under any insurance policy or medical reimbursement plan shall not be deemed a waiver of Dermatology and Allergy Specialists of Olympia's right to require payment directly from me. I understand and agree to adhere to Dermatology and Allergy Specialists of Olympia's financial/credit policy.

I have read and have a full understanding of the financial policy of Dermatology and Allergy Specialists of Olympia, PLLC and agree to these terms therein.

Signature: _____ Date: _____

_____ Relationship to Patient: _____

Print clearly signer's name



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Allergy Office: 703 Lilly Road NE, Suite 103, Olympia, WA 98506 Voice: (360) 413-8265 Fax: (360) 413-8868

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

MRN: _____

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Practices.

I, _____, or my Parent/Guarantor/Guardian _____,
(PRINT PATIENT NAME HERE) (circle one) (PRINT NAME HERE IF APPLIES)

acknowledge the opportunity to review and receive Dermatology and Allergy Specialists of Olympia, PLLC Notice of Privacy Practices.

OFFICE USE ONLY:

Patient refuses, or is unable to acknowledge receipt of the Notice of Privacy Practices.

Employee Signature

Date

Disclosures to Family, Friends, and Clinical Information Calls

We may need to disclose some of your **Private Health Information (PHI) / Billing / Scheduling** with some of your family members or friends. Please read and complete sections 1-3:

- I agree that this office may disclose my private health information to only the following individuals that are my **family members or friends**
- For Minors, please include ALL parental or family names to be included in release of information (We are sorry, but due to HIPAA laws if name is not listed, no information can be released) **(PLEASE PRINT).**

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR:

I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

2. How would you like us to **communicate with you** regarding clinical information (such as test results and treatment plans or appointments)? Following your visit, we will call and leave a message on the following:

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Other (____) _____

3. **Appointment Reminders:** Please check the preferences for receiving future appointment reminders and combine 2 options (if applicable):

Voice Message (Home/Cell) Text Message Email: _____

Signature

Date

Signers Relationship to Patient (if signed on behalf of the patient)



Dermatology and Allergy Specialists of Olympia, PLLC

304 West Bay Dr NW Olympia, WA 98502
 General Dermatology, STE 301; Mohs Surgery, STE 204

Welcome to our practice!

Please take the time to fill out the Health History Questionnaire below prior to your visit, as this will help speed the initial aspects of your visit with us.

Patient Name: _____ DOB: _____ Primary MD: _____

Pharmacy: _____

Past Medical History:

(Please add dates)

- Anxiety
 - Arthritis: Type _____
 - Asthma
 - Atrial Fibrillation / Irregular heartbeat
 - BPH (prostate)
 - Bone Marrow Transplant
 - Breast Cancer
 - Colon Cancer
 - COPD
 - Coronary Artery Disease
 - Depression
 - Diabetes
 - End Stage Renal Disease
 - Fibromyalgia
 - Gastroesophageal Reflux
 - Other _____
- Hearing Loss
 - Hepatitis: A B or C
 - Hypertension
 - HIV / AIDS
 - Hypercholesterolemia
 - Hyperthyroidism
 - Leukemia
 - Lung Cancer
 - Lymphoma
 - Prostate Cancer
 - Radiation Treatment
 - Seizures
 - Stroke

Please circle all that apply.

Past Surgeries: *(Please add dates)*

- Appendix (appendectomy)
 - Bladder (Cystectomy)
 - Breast: Mastectomy R L B
 - Breast: Lumpectomy R L B
 - Breast: Biopsy R L B
 - C Section
 - Colon (colectomy for cancer)
 - Colon (colectomy for diverticulitis)
 - Gallbladder (cholecystectomy)
 - Heart: PTCA
 - Heart: Mechanical Valve replacement
 - Heart: Biological Valve replacement
 - Heart: Transplant
 - Uterus: Hysterectomy _____
 - Joint replacement: Knee R L B
 - Other: _____
- Joint replacement: Hip
 - Kidney biopsy
 - Kidney removal (nephrectomy)
 - Kidney stone removal
 - Kidney transplant: Year _____
 - Ovaries: Endometriosis
 - Ovaries (Ovarian cancer)
 - Prostate removal (cancer)
 - Prostate: biopsy
 - Prostate (TURP procedure)
 - Skin Surgery
 - Biopsy
 - Basal cell carcinoma
 - Squamous cell carcinoma
 - Melanoma
 - Other: _____
 - Spleen (splenectomy)
 - Testicles (orchidectomy)
 - Tonsillectomy

Dermatology History:

- Acne
- Actinic Keratoses (pre-cancers)
- Asthma
- Basal cell skin cancer**
- Blistering sunburns
- Dry skin
- Eczema
- Other: _____
- Flaking or itchy scalp
- Hay Fever / Allergies
- Melanoma**
- Poison Ivy
- Precancerous or atypical moles
- Psoriasis
- Rosacea
- Squamous cell skin cancer**

** If yes, please list cancer, location, date, and treatment

Patient Name: _____ DOB: _____

Do you wear Sunscreen? No _____ Yes _____ (SPF _____)

Tanning salon? No _____ Yes _____ Past _____

Family history of skin cancer? No _____ Yes _____ Type: BASAL CELL SQUAMOUS CELL
MELANOMA UNKNOWN (circle one)

If yes, (circle) mother father sister brother daughter son uncle aunt nephew
grandmother grandfather grandson granddaughter Other _____

Please list any medications and supplements or vitamins that you are taking:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Are you allergic to latex? Yes _____ No _____ Reaction: _____

Please list any allergies to medicines or anesthesia that you may have and the reaction:

1.	3.	5.
2.	4.	6.

Social History:

Do you use illicit, intravenous or recreational drugs? Yes _____ Type: _____ No _____

Do you drink alcohol? _____ No _____ Yes (circle one) Less than 1 drink/day; 1-2 drinks/day; 3 or more drinks/day

Do you feel safe at home? Yes _____ No _____

Marital status? Single _____ Married _____ Divorced _____ Widowed _____ Partner _____

Occupation (s): _____

Hobbies / Leisure activities: _____

Where did you grow up and/or spend significant time in your life? _____

Do you or have you ever smoked? Current everyday smoker: _____ packs per day
_____ Occasional smoker
_____ Former smoker _____ year quit
_____ Never smoker

How often do you exercise? _____ Several times a day
_____ Once a day
_____ A few times a week or month
_____ Never

What is your caffeine use? _____ Several times a day
_____ Once a day
_____ A few times a week or month
_____ Never

(Women) Are you pregnant? _____ Yes _____ No _____ Are you planning? If yes, due date? _____