**Ronald Moy, M.D. Facial Plastic/Dermatology**

**77-6447 Kuakini Hwy. Kailua Kona, HI 96740**

**Appt #: 808-854-4039 FAX #: 808-442-4561(faxes must have “1”) email: hawaiimohsmd@gmail.com**

**PATIENT REGISTRATION FORM** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Jr. □ Sr.

 Last First Middle

Prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: □ Mr. □ Mrs. □ Ms. □Miss

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street # Street Name Apt # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State Zip

Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *□YES, It’s OK to send updates from Moy Facial Plastic/Derm.*

**SS#:\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ HI Driver’s License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ **Sex: □M □F Marital Status: M/ D/ S / Other**

**Employer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name Address Phone

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

**Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Pharmacy Zip Code

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY (If different from patient)** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Jr. □ Sr. Last First Middle

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street# Street City State Zip

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Sex: □M □F

**INSURANCE INFORMATION (Please present insurance cards at the time of check in)**

**Primary Insurance** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of patient to insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship of patient to insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_ I authorize** the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician. Patient or Responsible Party

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Moy Facial Plastic/Dermatology**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_** **General Medical History: Do you have or have you ever had any of the following? Y=Yes N= NO**

Y N ANXIETY Y N LYMPHOMA Y N RADIATION TREAT.

Y N DEPRESSION Y N ATRIAL FIBRILLATION Y N COLON CANCER

Y N LEUKEMIA Y N HEARING LOSS Y N HYPERCHOLESTEROL.

Y N ARTHRITIS Y N MIGRAINES Y N SEIZURES

Y N DIABETES Y N BPH Y N COPD

Y N LUNG CANCER N HEP. Y N PACEMAKER Y N STROKE

Y N ARTIFICIAL JOINTS Y N BONE MARROW TRANS. Y N HYPERTHYROID.

Y N END STAGE RENAL DIS. Y N HYPERTENSION Y N CORONARY ARTERY DIS.

Y N LUPUS Y N PROSTATE CANCER Y N HYPOTHYROIDISM

Y N ASTHMA Y N BREAST CANCER Y N VALVE REPLACE.

Y N GERD Y N HIV/ AIDS None/OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** **Do you have or have you ever had any of the following?** **Y=Yes N= NO**

Y N APPENDIX REMOVED Y N JOINT REPLACE.T, HIP, KNEE Y N TESTICLES REMOVED (RT, LFT, BIL)

Y N BIOLOGICAL VALVE REPLACE. Y N JOINT REPLACE. WITHIN 2 YEARS Y N GALLBLADDER REMOVED

Y N OVARIES REMOVED: Ovarian Y N JOINT REPLACE Y N KIDNEY TRANSPLANT

Y N BLADDER REMOVED Y N SKIN BIOPSY Y N HYSTERECTOMY: Fibroids

Y N HEART TRANSPLANT Y N BASAL CELL CANCER Y N OVARIES REMOVED: Endometriosis

Y N PROSTATE REMV: Prostate Cancer Y N TURP. Y N HYSTERECTOMY: Uterine Cancer

Y N MASTECTOMY (RT, LFT, BIL.) Y N SPLEEN REMOVED Y N PTCA

Y N PROSTATE BIOPSY Y N COLECTOMY: IBD Y N CORONARY ARTERY BYPASS

Y N LUMPECTOMY (RT, LFT, BIL) Y N KIDNEY STONE REMOVED Y N MECHANICAL VALVE REPLACE.

Y N BREAST BIOPSY (RT, LFT, BIL) Y N OVARIES REMOVED: Cyst

Y N BREAST REDUCE. (RT, LFT, BIL) Y N LIPOSUCTION: Location: Thighs/ Abdomen/ Back /Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N BREAST IMPLANTS Y N COSMETIC SURGERY: Type: Facelift/Nose/Chin/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NONE\_\_\_

**Skin Type: If 1st exposed to the sun in the summer without sunscreen, would you:**

□ Always burn, never tan □ Sometimes burn, always tan gradually □ Rarely burn

□ Always burn, sometimes tan □ Burn minimally, always tan well, tan profusely □ Never burn, deeply pigmented

**Skin History: Do you have or have you ever had any of the following? Y=Yes N= NO**

Y N ACNE Y N POISON IVY Y N PRECANCEROUS MOLES Y N PSORIASIS

Y N DRY SKIN Y N BASAL CELL SKIN CANCER Y N BLISTERING SUNBURNS Y N SQUAMOUS CELL

Y N MELANOMA Y N FLAKING OR ITCHY SCALP Y N HAY FEVER /ALLERGIES Y N ECZEMA

Y N ACTINIC KERATOSES NONE/OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you wear sunscreen? Y OR N If yes, what SPF? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you tan in a tanning salon? Y OR N**

FAMILY HISTORY: Circle any conditions affecting a blood relative. Specify who is affected below, then circle.

□ Melanoma □ Basal cell or squamous cell skin cancer □Psoriasis □ Eczema □ Hay-fever or allergies □Asthma □ Acne

**Family history of melanoma? Y or N If Y, which relative(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other family history?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Y N Pregnant or Breastfeeding? If not, method of birth control: \_\_\_\_\_\_\_\_\_\_\_ Y N Are you contemplating pregnancy?

Y N Tubal ligation (tubes tied) Y N Hysterectomy (if yes, uterus only

Y N Yeast infect. when taking antibiotics or uterus and ovaries?) Other Medical Problems or Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** **(Please check all that apply)**

**Sexual History**: **Illicit Drug Use Alcohol Use Safety Cigarette Smoking**

\_\_Not Sexually active \_\_Drug Use \_\_None \_\_Feel Safe @ Home \_\_Never Smoked

\_\_Active with One partner \_\_IV Drug \_\_< 1 drink daily \_\_Do not feel safe @ Home \_\_Quit: former smoker

\_\_Active with>One partner \_\_1-2 drinks daily \_\_Smoke less than daily

\_\_Active with same gender \_\_3+ drinks daily \_\_Smoke daily

**Moy Facial Plastic/Dermatology**

**PatientName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_**

Do we have your permission to: Leave a message on your answering machine at home? □Yes □No

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

Discuss your medical condition with any member of your household? □Yes □No

If yes, whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Responsible Party Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why are you here today?** (Please describe what the problem is, where it is located, how it bothers you, when it first began, what it first looked like, what you think caused it, was a biopsy done, and any treatments you have had so far):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear: □Dentures □Glasses □Contact Lenses

**Medication/ Allergies List**

MEDICATIONS: □No current medications

|  |  |  |
| --- | --- | --- |
| Med. Name | Dosage | How Often? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES/ SENSITIVITIES TO MEDICATION**:

□ No known/current allergies or medication sensitivities

|  |  |  |
| --- | --- | --- |
| Medication/Food | Reaction | How Often? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Moy Facial Plastic/Dermatology Photography Consent**

I consent to and authorize Ronald Moy, M.D. and his associates to take photographs of parts of my body (and/or pathology images) in connection with the dermatologic procedures (surgical or non-surgical) as performed by Ronald Moy, M.D. and his associates.

I understand that such photographs are used by Ronald Moy, M.D. and his associates in order to monitor the results of your treatment(s). I understand that such photographs may be published by Ronald Moy, M.D. and his associates in any print, visual, or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about dermatologic surgery methods.

This may include:

1. Patient Education- (showing patients my before and after photographs)

2. Advertisements- (showing before and after photographs)

3. Displays in the office- (showing before and after photographs)

4. Scientific/ Medical publications, presentations, and classes

5. Books, magazines, and other presentations

If there are any objections to any of the above items mentioned, please cross off the line and place your initials adjacent to the crossed off area.

I understand that, neither I, nor any member of my family will be identified by name in any publication.

I understand that, although an attempt will be made to hide my identity, in some circumstances the photographs may portray features which could make my identity recognizable.

I release and discharge Ronald Moy, M.D. and his associates, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

Your signature below signifies your understanding and willingness to comply with this policy.

**Patient or Responsible Party Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_/\_\_\_\_**

**Patient’s Signature Date**

**Moy Facial Plastic/Dermatology Office Policy for Insurance Billing**

Moy Facial Plastic/Dermatology is enrolled in numerous insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans, having different stipulations regarding which service(s) are covered and how often they may be performed. These plans differ depending on what type of contract you’ve selected with the insurance carrier.

Because we do not have access to your guidelines and stipulations, we must rely on you, the patient, to inform us each time of services exactly what those guidelines and stipulations are, especially if you need plastic or reconstructive surgery*. Unfortunately, if you do not inform us of special requirements of your insurance contract such as lab work, biopsies, and/or out-patient referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.*

**At the time of service, your co-pay or your 20% co-insurance and/or any outstanding deductible is due in full**.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. **Payment is required for all services at the time they are rendered**. If applicable copayments and deductibles will be collected. *We accept cash, check, or credit card*. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, **coverage will be pre-verified, and you will be asked to pay any unmet deductible, non-covered services and co-payments**. If your account must be turned over to our collection agency, a $10.00 collection fee will be added to your account.

**I have read and understand the office policy stated above and agree to accept responsibility as described.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_/\_\_\_/\_\_\_**

**Patient’s Signature Date**

**No Show & Cancellation Billing Policy**

Moy Facial Plastic/Derm. will collect Acct.t Bal., Co-Pays, Co-Ins, & Deduct. Amts at the time of service.

**No show and Late Cancellation Fees** (Cancellation without 24 hrs. of notice), will also be collected.

Fee:$30 for a follow up appt., $65 for new patients & cosmetic visits.

*All balances that remain outstanding for more than 30 days will accrue a 10% acct. fee.*

**Thank you for your understanding and compliance with our office policies.**

**Sincerely, Moy Facial Plastic/Dermatology**

**I, ,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HAVE BEEN INFORMED OF THESE POLICIES. Patient’s Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_\_/\_\_\_\_**

**Patient’s Signature**

**Moy Facial Plastic/Dermatology Billing Policy**

**Explanation of new changes to billing policy**

Due to changes in healthcare that have decreased physician reimbursements and increased the clerical and administrative work required to secure payment for medical services rendered, the Moy Facial Plastic/Dermatology must change its billing policy for the collection of copayments and payment balances, effective October 01, 2009.

Moy Facial Plastic/Derm. will no longer send invoices to patients for balances or co-payments. We will require a credit card to be kept on file. When the Explanation of Benefits (EOB) paperwork is received from your insurance company, which indicates the amount that the patient is responsible for (i.e. co-payment, deductibles, etc.), your credit card will be directly charged for those fees. You will ONLY be charged for amounts that your insurance company has determined to be the patient’s responsibility.

Another option is for the patient to pay for services rendered at the time of visit by cash, check, or credit card. When the insurance company makes its payment to us, a reimbursement will be forwarded to you in a prompt manner. As a courtesy to our patients, we will continue to bill insurance companies for services provided by our doctor(s).

Thank you for your understanding and compliance with our office policies.

Sincerely, Moy Facial Plastic/Dermatology

**REQUIRED: AUTHORIZATION TO CHARGE CREDIT CARD Patient**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Acct#\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have read the above policy and authorize the Moy Facial Plastic/Dermatology to keep my signature on file and to charge my credit card for the balance of charges to my account (deductibles, co-payments, and non-covered services) NOT paid by my insurance.**

**Credit card type: VISA MC AMEX 3 digit sec.code:\_\_\_\_\_\_\_\_**

**Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code:\_\_\_\_\_\_\_\_**

**Name on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expire Date:\_\_\_\_\_\_/\_\_\_\_\_\_**

**Cardholder’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_/\_\_/\_\_\_\_**

**RONALD MOY, MD**

**Office Address: 77-6447 Kuakini Hwy Kailua-Kona, HI 96740**

**APPT PHONE: 808 854 4039 FAX: 808 442 4561 (all faxes must include “1”)**

**Mailing address: PO Box 1773 Kealakekua 97650**

Please completely fill out the enclosed forms, including a copy of both the front & back of your health insurance cards, at least 2 weeks in advance of your appointment to assist the staff in making sure that we have all the information necessary to provide you with quality care and treatment.

***PLEASE SUBMIT YOUR PATIENT FORMS AT LEAST TWO WEEKS PRIOR TO YOUR APPT***

***Contact:*  Email: hawaiimohsmd@gmail.com FAX: 808 442 4561**

 **OR by Mail: Ronald Moy, M.D. PO Box 1773 Kealakekua, HI 96750**

You referred to Ronald Moy, M.D. Board certified Dermatologist, MOHS Surgeon and Facial Plastic Surgeon for skin cancer surgery.

**MOHS surgery is an outpatient procedure** performed under local anesthesia. Most patients can drive to their appointment. If the surgery is close to the eye area, we would recommend a driver or companion to ensure patient’s safety. Depending on the complexity of your skin cancer, you may spend several hours in the office for this surgical procedure. *For additional information visit: www.mohscollege.org*

**Prep for MOHS surgery:** plan on spending much of the day at our office.

Morning of the surgery: please eat a good breakfast and take all your regular medications.

Wear comfortable casual clothes. Bring a sweater or small blanket for comfort.

Optional: bring some personal snacks, drinks, and reading material or personal music headsets or iPod while waiting for your surgical result in between the MOHS layer(s).

**WHAT IS MOHS SURGERY?** Mohs is the excision of a cancer from the skin, followed by detailed mapping and complete microscopic examination of the cancerous tissue and the margins surrounding it. Skin cancer may not always be obvious to the naked eye; therefore, it is removed with a thin layer(s) of skin. Then tissue specimen is mapped and immediately processed by the onsite laboratory. If the skin margins are cancer free, surgery ends. If not cancer free, then more tissue is removed. This procedure is repeated until the final tissue layer examined is clear of cancer*. Any surgical procedure will result in a scar*. MOHS surgery will try to conserve as much of the healthy tissue as possible. Dr. Moy will try to camouflage the surgical scar, and with follow up appointment(s), scar revision(s) may be discussed and as part of post op visit(s).

**MOHS surgery offers a 99 % cure rate for most skin cancers**. MOHS provides the greatest chance of cure when other methods have failed. MOHS surgery benefits are: removal of the cancer, conservation of healthy tissue, wound repair is accomplished on the same day along with highest consideration of providing the best cosmetic possible. Some wound may be left to heal naturally. More complex wound post op care will be discussed along with best options and techniques for optimal cosmetic results.

If you have any questions regarding insurance coverage, patient co-pays or deductibles, please contact Dr. Moy’s billing office directly: 310 274 5327.