PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

Patient Information

Date		**DOB**	_____/____/____
Patient Name		**Gender**	**Male/Female**
Address		**City, State, Zip**	

Race	**Ethnic Group**	**Language**
☐ Declined ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race	☐ Declined ☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Arabic ☐ Russian ☐ Chinese ☐ Spanish ☐ English ☐ Vietnamese ☐ French ☐ Japanese ☐ German ☐ Other

Pharmacy Name	
City	
Cross Street(s)	

Referring Physician	
City	
Cross Street(s)	

Primary Care Physician	
Address/City	
Phone/Fax	

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

Patient Name (PLEASE PRINT) _____ **Date of Birth** _____

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our practice at 855-535-7175.

Please note that Forefront may communicate with you in the following ways, unless you instruct us otherwise:

- In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff. If you are signing this form via an electronic method which does not allow you to provide your preferred phone number and email address above, these communication policies shall apply to the phone numbers and email addresses you provide to Forefront staff for the above stated purpose.

Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Email Address _____	

- Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.
- You specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront and its representatives at the number(s) provided above or an appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, billing and collection information and marketing or advertising messages offering products or services that may be of interest to you. Forefront may receive direct or indirect payment for these marketing messages. You understand that by providing your telephone number and/or e-mail address to Forefront, you consent to being contacted using the above-described methods. If you receive communications from Forefront, you will be given the opportunity to opt-out of future communications by responding "STOP" or through another easily used mechanism, should you make that choice. You understand that you are not required to sign this agreement in order to receive treatment and that your consent is not a condition of purchasing or using any services offered by Forefront.
- If you have any questions about our Notice, please contact our compliance department – Phone: 920-663-0505, e-mail: compliance@forefrontderm.com

I acknowledge receipt of Forefront's Notice of Privacy Practices. I understand and agree to how Forefront may communicate with me, as stated above.

X _____ _____

(Signature of Patient or Legal Representative) **Date**

Parents may not sign for children over the age of 18 (or 19 years of age in Alabama).

If signed by someone other than patient, indicate relationship: _____

Print name _____

(Legal representative)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign this Acknowledgement even though the patient was asked to do so and the Notice of Privacy Practices were made available to the patient.

☐ Other _____

_____ _____

Employee Name Date

Updated 5/22/19

FOREFRONT DERMATOLOGY®
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Patient Communication & Financial Policies

The following are internal policies set in place by Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Signature is required before services can be provided.

Patient Communications: In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.

Research: I authorize Forefront to contact me regarding any research study in which I may be eligible to participate relating to my care.

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. If your insurance deems a service to be not covered by your insurance plan you agree to be responsible for the balance of this service. Claims not paid by your insurance carrier within 90 days will be considered a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the Practice from your insurance company. If your insurance company reimburses you directly for any outstanding amounts due to us, payment will be expected by us within 10 days. I hereby assign to Forefront all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Bad Debt Account Status: I realize that if my account is in bad debt I will be required to pay a **down payment** of $150.00 prior to my scheduled appointment. In the event that this down payment exceeds the visit cost, the overpayment will first be applied towards any outstanding balance or bad debt balance and any remaining balance will be refunded to you. I realize that if my account is sent to collections, Forefront may also elect to dismiss me as a patient from the practice. If I pay off my bad debt account, my account will be returned to good standing status and I will not be required to make a down payment on future visits unless I am placed into collections again in the future. This provision does not apply to patients who currently have Medicaid health insurance coverage or to patients who are currently under bankruptcy or any other insolvency protection.

Financial Responsibility: A $35.00 charge will be added for any non-sufficient funds notice from the bank. I understand and agree that I will be responsible for all legal fees and other costs of collection if my account is turned over to an attorney or agency for collection in which case your visit/s with our office may become a matter of public record.

Medicaid Affidavit:

ALL patients must answer ⟶

At this time I,_____ represent and warrant that I
(Print Your Name)

(DO) or (DO NOT) have ***Medicaid coverage***.

***(Circle One** - if unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot circle one, please inform the staff immediately if you have Medicaid health insurance coverage)*

If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office you may be responsible for the balance of your bill. Not all locations and providers participate in Medicaid programs. The patient will be responsible for the full amount of services provided when this circumstance is applicable.

Non-insured Patients: Non-insured patients will be charged a **down payment** prior to seeing a provider on the date of service. This is not considered payment in full. The down payments are as follows:

- New patient Office Visit: $178
- Established Patient Office Visit: $150
- Excision Visit: $800
- MOHS Visit: $1,000

Final charges will be determined after the provider sees the patient and a complete assessment is made. The provider may require payment in full for procedural services prior to rendering such a service. If the balance is paid in full within two weeks from the date of the statement, a 20% discount for cash/check or a 15% discount for credit card will apply. ***This discount does not apply to Cosmetic procedures and injectables.***

Co-payments, Co-insurance, Deductible, & Cosmetic Procedures: Payment is due on the date of service prior to seeing the provider. Deductible amounts may be collected prior to the provider completing the service. Payment for a cosmetic procedure is due in full prior to treatment. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction.

Procedure Pricing

I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment.

X _____ _____ _____/_____/_____until revoked
Signature of Patient or Legal Representative *Date of Birth* *Date*

_____ *Relationship to Patient*

Updated 5/22/19

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Consent to Clinical Procedures

Patient Name: _____ **Date of Birth:** _____

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my visit with Forefront Dermatology, S.C. or its affiliated practice ("Forefront").

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen <u>will be</u> sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges.

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly**.**

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is notguaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your provider if it is a potential during your procedure.

I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician.

If deemed appropriate, I **do___or do not___** ***(Initials)*** consent to photographs and digital images being taken for medical education, training, professional publications or sales purposes. No photographs or digital images revealing the patient's identity will be used without my consent. If the patient's identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission. If you are signing this form via an electronic method which does not allow you to check one of the boxes above, please notify Forefront staff if you do not wish your photos to be used as set forth in this paragraph.

Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Forefront. I do not impose any limitations on Forefront and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

_____

Patient signature / Date

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian signature/ Date ***Relationship to Patient***

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Office Policy

Welcome! We look forward to seeing you for your appointment. Enclosed you will find information forms that we would like you to complete prior to your first visit. Please mail them back to us or bring them with you for your appointment. Your clear understanding of our office policy is important.

Your First Visit

Please bring your insurance card on your first visit so that it may be copied for your file. It is a good idea to bring your card to every appointment. If your insurance ever changes, it is especially important to let us know and bring your new card. Please arrive 15 minutes before your first appointment so that all paperwork can be completed.

Contracted HMO and PPO Plans

If our physicians are covered providers in your PPO or HMO plan, any co-pay or deductible is due at the time of service. The balance of your bill will be billed to your insurance, if your HMO requires a referral form from your primary physician; it is your responsibility to have this by the day of your visit. If an appropriate referral is not provided, we cannot bill your insurance unless prohibited by the terms of our contract with your insurance company and you will be fully responsible for the bill at the time of service.

Non-contracted Insurance and Self-Pay Patients

If our physicians are not contracted with your insurance plan or you do not have health insurance, full payment is due at the time of service. We will provide you with a receipt in which you may use to file the insurance claim yourself.

Medicare

Our physicians are Medicare Providers and we do accept assignment on covered services. All Medicare patients are responsible for their 20% co-insurance and annual deductible and these are due at the time of service.

Non-Covered Services

Cosmetic procedures and other medically unnecessary services will not be billed to your insurance and are the patient's responsibility for payment in full at time of service.

Minor Patients

All minor patients (less than 18 years of age) must be accompanied by their parent or legal guardian on their first visit. If under the age of 16, the patient may only be seen with a parent or legal guardian present. Surgical or laser procedures as well as any Accutane related visits must have a legal guardian present if the patient is under the age of 18.

Payments

Payments may be made by cash, check, Visa, MasterCard, or Care Credit. Payments greater than $200 will not be accepted in cash. A cashier's check or money order will be accepted in lieu of cash.

Missed Appointments

If you are unable to keep your appointment please notify our office at least 24 hours in advance. Failure to provide 24 hour notice will result in a no-show charge and will be collected to the extent permitted by applicable law or by applicable payor contract. The no-show fee is $50 for a Monday-Friday regular medical visit and $100 for Saturday appointments. The no- show fee is $99 for a cosmetic consultation and $250 for a cosmetic procedure. No-show charges are not billable to your insurance.

Scheduling

Patients are not always called in order of arrival due to the fact that appointments may be with any one of our providers, nurse, or the clinical staff. We make every effort for you to be seen at your scheduled time; however, unforeseen emergencies or complicated or unusually ill patients may cause us to run behind. Please be understanding in that someday your emergency or illness may affect others.

Children

Please do not leave children under the age of twelve unattended in the waiting room

X_____ _____

(Signature of Patient or Legal Representative) Date: