PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

Patient Information

Date _____

Patient Name _____ **DOB** _____
Last First Middle MM/DD/YY

Address _____
Street Apt/Unit No. City State Zip

Phones H_____ C _____ W _____ Ext#_____

Preferred Contact # ☐ Home ☐ Cell ☐ Work **I authorize contact by cell** ☐ Y ☐ N **Employer** _____

Gender ☐ Male ☐ Female **Marital Status** ☐ S ☐ M ☐ W ☐ D **Student** ☐ Y ☐ N **SS #** _____

Sign me up for Portal (Email Required) ☐ Y ☐ N ☐ Already Signed Up

Email _____

Pharmacy _____ Cross Street(s) _____ City _____

Referring Physician _____ Phone _____ Fax _____

Primary Care Physician _____ Phone _____ Fax _____

Race
☐ Declined
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other

Ethnic Group
☐ Declined
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Language
☐ Arabic ☐ Chinese ☐ English
☐ French ☐ German ☐ Japanese
☐ Russian ☐ Spanish ☐ Vietnamese

REQUIRED PRIMARY INSURANCE INFORMATION

Primary Insurance Company _____

Policy Holder's Name _____ DOB _____ Relationship _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company _____

Policy Holder's Name _____ DOB _____ Relationship _____

Name _____

DOB _____

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MEDICAL HISTORY

Dermatologic History: _____ None
Melanoma _____ No _____ Yes Explain: _____
Basal Cell Carcinoma _____ No _____ Yes Explain: _____
Squamous Cell Carcinoma _____ No _____ Yes Explain: _____
Psoriasis _____ No _____ Yes **Eczema** _____ No _____ Yes
Hay Fever ____ No _____ Yes **Asthma** _____ No _____ Yes

Medical History: _____ None **Date**
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Surgical History: _____ None **Date**
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Family History: _____ None
Melanoma _____ No _____ Yes Explain: _____
Basal Cell Carcinoma _____ No _____ Yes Explain: _____
Squamous Cell Carcinoma _____ No _____ Yes Explain: _____
Psoriasis _____ No _____ Yes **Eczema** _____ No _____ Yes
Hay Fever _____ No _____ Yes **Asthma** _____ No _____ Yes

Allergies:
1._____
2._____
3._____
4._____
5._____

Social History:
Occupation:
_____
Alcohol: ___Yes ___ No
Amount: _____
Tobacco: ___Yes ___ No
Amount: _____
Drug Use: ___Yes ___ No
Explain: _____
Sun Exposure: ___ Heavy
___ Moderate ___ Minimal
History of Blistering:
Sunburn ___ Yes ___No
Tanning Bed Use:
___ No ___Yes, Current
___ Yes, Past
Sunscreen: ___ Always
___ Occas. ___ Never

Other Pertinent Family History: _____ None
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Current Medications	Dose	Frequency

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Patient Communication & Financial Policies

The Following are internal policies set in place by the administration of Dermatology Associates of Wisconsin S.C., d/b/a Premier Dermatology, a Forefront Dermatology practice. Signature is required before services can be provided.

Patient Communications

Reminders of upcoming scheduled appointments may be left on your answering machine or with a family member who answers the telephone at your residence, and/or sent via email, text message, or post card to your household. Notification regarding the availability of pathology or laboratory results may also be left on your answering machine or with a family member who answers the telephone at your residence. Actual results, however will not be left on your answering machine, though they may be communicated to those family members or friends involved in your care, or to your authorized representative. If you provided a cell phone number in your contact information, we will contact you on your cell phone and, if needed, may leave a message (including, without limitation, voicemail and text message).

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 will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will become your responsibility as 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 pays copays, coinsurance, or other similar charges. 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 & Bankruptcy Account Status

I realize that if my account is in bad debt or bankruptcy status I will be required to pay $150.00 prior to my scheduled appointment; this payment will serve as a down payment toward services to be rendered at the encounter for which I am here. If, after the provider has billed for services and/or the insurance has responded and the practice determines that I do not owe the $150.00 for the current encounter and if I am not currently under bankruptcy or any other insolvency protection from collection on past debt, the practice will review my account to see if I owe a balance on any other recent encounters or if I owe anything to Americollect, the practice's collection agency. If it is determined that I do owe on past balances and am not protected from collection, the practice will apply the remaining amount towards such amounts owed. If I owe less than what was overpaid on the account a refund will be returned to me for the appropriate amount. I realize that if my account is sent to collections, Forefront Dermatology may alternatively elect to dismiss me as a patient from the practice. If I pay off my account with Americollect, my account will be returned to good standing status with the practice and I will not be required to pay $150.00 prior to appointments unless I am placed into collections in the future.

Non-sufficient Funds

A $35.00 charge will be added for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit/s with our office may become a matter of public record.

Medicaid Insurance Coverage (*ALL patients must fill this out*)

At this time I, _____ warrant and represent that I (DO) or (DO NOT) have **Medicaid** health insurance coverage.
Print Your Name ***circle one***

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 fee prior to seeing the physician/examination on the date of service. These funds will be allocated to the services rendered by the physician for that day however these fees serve only as a down payment and are 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 physician sees the patient and a complete assessment is made. The physician may require payment in full for procedural services prior to rendering such a service. Additional fee information is available upon the patient's request. A statement with the balance due for services provided will be mailed to you within a few days. 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*. _____ *Initial*

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 physician 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 *Relationship to Patient* *Date*

*DOB:*_____

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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. 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 Dermatology may communicate with you in the following ways, unless you instruct us otherwise:

- Reminders of upcoming scheduled appointments may be left on your answering machine or with a friend or family member who answers the telephone at your residence, and/or sent via e-mail, text message, or post card to your home address.
- Notification regarding the availability of pathology or laboratory results may also be left on your answering machine or with a friend for family member who answers the telephone at your residence.
- Results of pathology or laboratory tests will not be left on your answering machine, though they may be communicated to those family members or friends involved in your care, or to your authorized representative.
- If you provided a cell phone number in your contact information, we will contact you on your cell phone and, if needed, may leave a message (including, without limitation, voicemail and text message).

If you have any questions about our Notice, please contact: Cathy Lacenski – Phone: (920) 663-9012, e-mail: Clacenski@forefrontderm.com

I acknowledge receipt of the Notice of Forefront Dermatology. I understand and agree to how Forefront Dermatology 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.

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 patient was given the Notice of Privacy Practices.

☐ Other: _____

_____ _____

Employee Name Date

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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 use 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 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, grandparent, or legal guardian on their first visit. If under the age of 16, the patient may only be seen with a parent, legal guardian, or grandparent 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 hours notice will result in a no-show charge and will be collected to the extent permitted by law. The no- show fee is $50 for a Monday-Friday regular medical visit and 50% of the anticipated cost of scheduled surgical or cosmetic procedures. A Saturday no-show fee is $100. Cosmetic services require a 48-hour notice of cancellation. The no-show fee is $99 for a cosmetic consultation.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: