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<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ White<br>☐ Other Race | ☐ Declined<br>☐ Hispanic or Latino<br>☐ Not Hispanic or Latino | ☐ Arabic ☐ Russian<br>☐ Chinese ☐ Spanish<br>☐ English ☐ Vietnamese<br>☐ French ☐ Japanese<br>☐ German ☐ Other |

| | |
|---|---|
| **Pharmacy Name** | |
| City | |
| Cross Street(s) | |

| | |
|---|---|
| **Referring Physician** | |
| City | |
| Cross Street(s) | |

| | |
|---|---|
| **Primary Care Physician** | |
| Address/City | |
| Phone/Fax | |

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# Intake and History Form

Name: _____ Date: _____

## Past Medical History

**List any medical conditions you currently have / have had:**

_____

_____

## Past Surgical History

**Have you had any surgeries?**

_____

_____

## Skin Disease History

**Have you had any of the following?**

- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer

**Do you wear Sunscreen?**

○ Yes ○ No

**Do you have a family history of Melanoma?**

○ Yes ○ No

## Medications

_____

_____

## Allergies

_____

_____

## Social History

**Smoking Status (please choose one):**

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

**Alcohol Intake (please choose one):**

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

## Family History

Please include only first-degree relatives:

_____

_____

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# Patient Communication & Financial Policies

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

Patient Communications**:** Confidential messages 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. You understand that you are not required to agree to this provision in order to receive treatment.

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 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 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 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 future encounter. If, after the provider has billed for services and/or the insurance has responded, 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 by applicable law, 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 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 a provider on the date of service. These funds will be allocated to the services rendered by the provider 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 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. 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, S.C., d/b/a Premier 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:

- In Forefront Dermatology's discretion, a confidential message 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.

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

- Forefront Dermatology 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.
- **Unless you check below**, you specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, but not limited to, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront Dermatology and its representatives at the residential or cellular telephone number provided above or an appropriate e-mail address, not only in order to communicate appointment reminders, and notifications regarding the availability of pathology or laboratory results, but also for marketing or advertising messages offering products or services that may be of interest to you. Forefront Dermatology may receive direct or indirect payment for these marketing or advertising messages. You understand that by providing your telephone number and/or e-mail address to Forefront Dermatology, you consent to being contacted using the above-described methods. You understand that you are not required to sign this agreement in order to receive treatment. You further understand that you are not required to give this consent and that your consent is not a condition of purchasing or using any services offered by Forefront Dermatology.

  **Marketing Related Opt-Out:** *(Check all that apply)* ☐ Do Not Text ☐ Do Not Email

- 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 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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# 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 Dermatology Associates of Wisconsin, S.C., d/b/a Premier Dermatology, a Forefront Dermatology 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 **will be** 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. _____ ***(Initials)***

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. _____ ***(Initials)***

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 not guaranteed.
- 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 physician 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. They will not be used for any other purpose without a proper consent.

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

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.

_____ ***(Initials)***

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Premier Dermatology. I do not impose any limitations on Premier Dermatology 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** Witness 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 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 hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. 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**_____ Today's Date _____
(Signature of Patient or Legal Representative)