PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

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