FOREFRONT DERMATOLOGY®

# History and Intake Form

**Name:** **MRN**(staff use only):

**Date of Birth:**

**Pharmacy You Use:** **City or Zip code:**

**Family Doctor:**

**Past Medical History**: (please circle all that apply)

NONE
Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other _____

**Past Surgical History**: (please circle all that apply

NONE
Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other _____

**Skin Disease History**: (please circle all that apply)

NONE
Acne
Actinic Keratoses
Asthma
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Poison Ivy
Precancerous Moles
Psoriasis

**History of Skin Cancer:**

Basal Cell Skin Cancer
Squamous Cell Skin Cancer
Melanoma

Other _____

Do you wear Sunscreen? ☐ Yes ☐ No
If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____

**Medications**: (Please list all current medications)

_____
_____
_____
_____

**Allergies**: (Please list all allergies)

_____
_____
_____
_____

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

**Cigarette Smoking:**

- ☐ Never
- ☐ Current
- ☐ Former

**Alcohol Use:**

- ☐ None
- ☐ less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, 4 or more drinks in a day for women or 4 or more drinks in a day for any adult over 65? ☐ **none** ☐ **once** ☐ **two or more**

**Family History:** (Only first degree relatives)

_____
_____
_____

**ALERTS**: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to latex
Artificial heart valve
Artificial joint replacement
Blood Thinners
Defibrillator
History of fainting or vasovagal episodes
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Pregnant or trying to get pregnant

FOREFRONT DERMATOLOGY
AND AFFILIATED PRACTICES

# 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 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.

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 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 provider if it is a potential during your procedure.

COVID-19: I recognize that Forefront has implemented reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with an elective treatment or procedure. I understand that possible exposure to COVID-19 before/during/after my treatment or procedure may result in extended quarantine/self-isolation, additional tests, hospitalization and rehabilitation and the risk of other potential complications, including death. I hereby acknowledge the risk of becoming infected with COVID-19 through this elective treatment or procedure.

I authorize pictures to be taken before, during and after the procedure. These pictures and digital images will become part of your medical record and may be used or disclosed as permitted by HIPAA. They may also be sent to your family physician and/or referring physician.

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***

*Updated 6/4/2020*

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

# NOTICE OF PRIVACY PRACTICES

Effective 6/4/2020

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Your Health Care Information - Protecting Your Privacy**
It is your right as a patient to be informed of the privacy practices of your health care provider as well as your privacy rights with respect to your personal health information. This Notice of Privacy Practices (the "Notice") is intended to provide you with this information.

**Forefront Dermatology Responsibilities**
It is your right as a patient to be informed of Forefront Dermatology's legal duties with respect to protection of the privacy of your protected health information ("PHI").

Forefront Dermatology is required to:
- Maintain the privacy of your health information;
- Provide you with a notice of the legal duties and privacy practices regarding PHI collected and maintained about you;
- Notify you if you are affected by a breach of unsecured PHI; and
- Abide by the terms of this notice.

Forefront Dermatology reserves the right to change our privacy practices and update this Notice accordingly. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any PHI we receive in the future.

Forefront Dermatology will not use or disclose your PHI without your authorization, except as described in this notice.

**Your Rights Regarding Your PHI**

> **NOTE**: *All written requests must be made in writing to the Forefront Dermatology Privacy Officer at the address below.*

**You have the right to:**

- **Request a restriction on certain uses and disclosures of your PHI.**
  You have the right to request restrictions on certain uses and disclosures of your PHI. Requests for restrictions must be in writing, as specified above. You must advise Forefront Dermatology: (1) what information you want to limit; (2) whether you want to limit Forefront Dermatology's internal use, disclosure to third parties, or both; and (3) to whom you want the limit(s) to apply. We are not required to agree to your request, except when you request that we restrict disclosure of your PHI to a health plan for a health care item or service for which you have paid out-of-pocket in full and the disclosure is for the purpose of carrying out payment or health care operations, and not otherwise required by law.

- **Receive Confidential Communications.**
  You have the right to request that Forefront Dermatology communicate your PHI to you by alternative means or at alternative locations. We will use our best efforts to accommodate reasonable requests. For example, you may request to be contacted at a phone number that is different from the phone number listed in your health care record.

- **Inspect and obtain a copy of your health record.**
  You have the right to inspect and obtain a copy of your health care record. This request for access to your health care record must be submitted in writing, as specified above. This right may not apply to certain types of psychotherapy notes. Forefront Dermatology may charge you a reasonable fee for a copy of your health care record.

  We will inform you if we cannot fulfill your request, and you can ask us to reconsider the denial by contacting our Privacy Officer at the address below. Depending upon why the denial was made, we may ask a licensed health care professional to review your request and the denial.

- **Amend your health record.**
  If you believe that any PHI in your records is incorrect or incomplete, you may submit a written request (as specified above) to correct the information in your records. We may deny your request if you ask us to amend PHI that is: (i) accurate and complete; (ii) not created by Forefront Dermatology; (iii) not part of the PHI kept by or for Forefront Dermatology; or (iv) not PHI that you would be permitted to inspect and copy. If we deny your request, you can ask us, in writing, to review that denial.

- **Obtain an accounting of disclosures of your PHI.**
  You have the right to an "accounting of disclosures," which is a list of disclosures of your PHI that we have made to outside parties, except for: (i) those necessary to carry out treatment, payment and healthcare operations; (ii) disclosures made before April 14, 2003; (iii) disclosures made to you; (iv) disclosures you authorized; and (v) certain other disclosures. You may receive one accounting per year at no charge; we may charge you a reasonable fee for each subsequent request.

  Your request for an accounting of disclosures must be in writing, as specified above, and must state a time period that may not be longer than six years prior to the date the accounting was requested.

- **Obtain a paper copy of the notice upon request.**
  You have the right to obtain a paper copy of the notice upon request. For example, if you received the notice electronically, you may request that Forefront Dermatology provide a paper copy of the notice.

**How We May Use and Disclose Your PHI**

- **For Treatment.** Forefront Dermatology may use or disclose your PHI in the provision, coordination or management of your health care.

Example: Physicians involved in your care will need PHI relating to your history, symptoms, disease and prognosis in order to coordinate care for you.

Example: Forefront Dermatology may use your PHI to provide you with an appointment reminder.

Example: Forefront Dermatology may send you information about treatment alternatives or other health related services that may be of interest to you.

- **For Payment.** Forefront Dermatology may use or disclose your PHI to obtain reimbursement for the provision of health care services. The bill may include information that identifies you, your diagnosis and your treatment.

Example: Forefront Dermatology may use or disclose your information to your insurer to obtain payment for the provision of health care services, or to obtain prior authorization for the service.

- **For Health Care Operations.** Forefront Dermatology may use or disclose your PHI for our health care operations.

Example: Forefront Dermatology may use your PHI to assess the care and outcomes in your case or to, as a whole, improve the quality and effectiveness of the health care we provide.

- **To Business Associates.** Forefront Dermatology may disclose your PHI to "business associates" who provide services to or on behalf of Forefront Dermatology.

- **Communication with Individuals Involved in Your Care.** Unless you tell us otherwise, we may share your PHI with friends, family members or others you have identified or who are involved in your care. We may share your PHI with disaster relief organizations so that your family, friends or others you have identified can be notified of your location and condition in case of disaster or other emergency.

- **Research:** Under certain circumstances, Forefront Dermatology may use or disclose your PHI for research purposes. Under certain circumstances, we may share your PHI for research purposes without your written permission. All research projects are, however, subject to a special approval process. Most research projects will require your specific permission if a researcher will have access to information that identifies you.

- **As Required by Law**: Forefront Dermatology will disclose your PHI where required by law. For example, federal law may require your PHI to be released to an appropriate health oversight agency, public health authority or attorney.

- **Workers compensation:** Forefront Dermatology may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

- **Public Health:** We may disclose your PHI for public health activities. For example, Forefront Dermatology may disclose your protected PHI to State agencies for the purpose of statutory reporting.

- **Health Oversight Activities:** We may share your PHI with a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.

- **Public Safety:** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Victims of abuse, neglect or domestic violence:** Forefront Dermatology may disclose PHI if Forefront Dermatology reasonably believes that an individual is a victim of child or elderly abuse.

- **Judicial and Administrative Proceedings:** Forefront Dermatology may disclose your PHI in response to a court or administrative order, a subpoena, a warrant, a discovery request or other lawful due process.

- **Law enforcement:** Forefront Dermatology may disclose your PHI for law enforcement purposes as authorized or required by law or other lawful due process. For example, we may be required by law to report certain types of wounds or other physical injuries.

- **Coroner or Medical Examiner:** Forefront Dermatology may release PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.

- **For cadaveric organ, eye or tissue donation purposes:** We may release your PHI to organizations that handle organ, eye or tissue donation and transplantation.

- **Specialized Government Functions:** If you are a member of the armed forces, we may share your PHI with the military for military command purposes. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- **Correctional Institution:** Should you be an inmate of a correctional institution, Forefront Dermatology may disclose to limited staff of the institution or agents thereof PHI necessary for your health and the health and safety of other individuals.

**Other Uses and Disclosures of Your PHI**

We may use or disclose your PHI as described above without your authorization. Other uses and disclosures of PHI not described in this Notice will be made only with your authorization. We will obtain your written authorization for: (i) most uses and disclosures of psychotherapy notes; (ii) most uses and disclosures of PHI for marketing purposes, as defined by HIPAA; and (iii) disclosures that constitute a sale of PHI, as defined by HIPAA. If you give us authorization to use or disclose your PHI, then you may revoke that authorization, in writing, at any time. Your revocation will be effective upon receipt, but will not be effective to the extent that Forefront Dermatology or others have acted in reliance upon the authorization.

**Patient Complaint Process**

If you believe your privacy rights have been violated, you may file a complaint with Forefront Dermatology or with the Office for Civil Rights of the United States Department of Health and Human Services electronically via the OCR Complaint Portal, or on paper by mail, fax or via e-mail (OCRComplaint@hhs.gov). We will not take any action against you for filing a complaint.

To file a complaint with Forefront Dermatology please contact the Forefront Dermatology's Privacy Officer who will provide you with the necessary assistance.

**Questions or Concerns**

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact:

Compliance Officer
Forefront Dermatology
Phone: 920-663-0505

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
AND AFFILIATED PRACTICES

# 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*

Advanced Dermatology & Skin Care Centre

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 Advanced Dermatology & Skin Care Centre. 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.

| ☐ RESTRICTED – DO NOT RELEASE INFORMATION | ☐ ALLOW – RELEASE INFORMATION TO PERSON (S) BELOW | |
|---|---|---|
| YOU MUST LIST FULL NAMES OF EACH PERSON(S) | | |
| | | |

| **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

FOREFRONT DERMATOLOGY
AND AFFILIATED PRACTICES

# Minor Patient Consent Form

Patient's Name: _____ Patient's Date of Birth: ____/____/____

**All minors must be accompanied by a parent or a legal guardian for their first visit with our practice. Unfortunately, due to informed consent and contracting laws, we cannot treat your child for a new condition until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. If a parent or legal guardian is not present at the time of a minor child's appointment, the child can only be evaluated, and only if a parent or legal guardian consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a parent or legal guardian after receiving the appropriate information.**

1. **Evaluation authorization** by parent/legal guardian only: *(Check one box only)*

   ☐ I will be attending all appointments with my minor child and do not want my minor child evaluated unless I am present.

   ☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to authorize any additional treatments, my minor child will need to come back for additional treatment after I provide the necessary authorization and consent.

2. **Treatment authorization** by parent/legal guardian only: *(Check one box only)*

   ☐ I will be attending all appointments with my minor child and will be present to give consent if a procedure is recommended. You may not treat my minor child without my authorization and approval at the time of treatment.

   ☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for ongoing care of any previously diagnosed condition for which I have already provided informed consent.

3. **Insurance information:**

   If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification to the receptionist.

   If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

   Name of parent/guardian: _____ Parent/Guardian's date of birth: ____/____/____

   Parent/Guardian's relationship to patient: _____

4. **Payment Policy:**

   The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. We will only respond to a court order that directs Forefront Dermatology to act in a certain way.

   Guardian Signature: _____ Today's Date: ____/____/____

5. **Parent/Guardian Contact information:**

   Father/Guardian (please print): First name_____ Last name _____

   Phone (8 am-5 pm):_____-_____-_____ home / mobile / work (circle one)

   Secondary # (8 am-5 pm):_____-_____-_____home / mobile / work (circle one)

   Mother/Guardian (please print): First name_____ Last name _____

   Phone (8 am-5 pm):_____-_____-_____ home / mobile / work (circle one)

   Secondary # (8 am-5 pm):_____-_____-_____home / mobile / work (circle one)