FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Notice of Privacy Practices Acknowledgement of receipt

Patient Name: _____ **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 (collectively, "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 on our website at forefrontdermatology.com or 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. I understand the risks of communication by unencrypted email and SMS text.
- 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 HIPAA Privacy Officer – Phone: 920-663-0505, e-mail: privacy.officer@forefrontderm.com

Information Exchange: By signing this form you are opting in to Forefront's ability to participate in and share information with health information exchanges (HIEs). A Health Information Exchange is a secure system that allows doctors, hospitals, and other healthcare providers to share your health information electronically. HIEs help your healthcare team by giving your doctors a complete picture of your health, ensuring they have the right information at the right time Protecting your privacy is a top priority. HIEs use strict security measures to keep your data safe. If you desire to opt out of participation, email your request to compliance@forefrontderm.com or call 920-663-0505.

I hereby acknowledge receipt of Forefront's Notice of Privacy Practices and understand and agree to how Forefront may communicate regarding the patient; I do so as the patient or legal representative of the above referenced patient if the patient does not have the legal capacity to acknowledge (for example: minors under the age of 18 (19 in the state of Alabama) or incapacitated patients with an active power of attorney).

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient

For Office Use Only
Complete this section if this form is not signed and dated by the patient or patient's legal representative.
Reasons why the acknowledgement was not obtained:

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

_____ _____

Employee Name Date

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Financial & Patient Communication Policies

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

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. Forefront is unable to accept any revisions to this form and any attempted changes shall be null and void.

Assignment of Benefits: 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.

Insurance Filing: If the clinician treating you is contracted with your insurance plan, we will furnish information required by the insurance plan to receive payment. 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 to the extent permitted by applicable law and insurance plan contracts.

If the clinician treating you is not contracted with your insurance plan, we will bill your insurance plan for charges incurred at our clinic as a courtesy to you. Please remember that your health insurance is a contract between you and your insurance plan. We will furnish information required by the insurance plan to receive payment. Our office will make an attempt to settle any outstanding bill with your insurance plan. You agree to be responsible for the balance of the costs of the services provided to you that are not reimbursed by your insurance plan. Benefits should be paid directly to the Practice from your insurance plan. If your insurance plan reimburses you directly for any outstanding amounts due to us, payment will be expected by us within 10 days.

Co-payments, Co-insurance, Deductible, & Cosmetic Procedures: Payment is due on the date of service prior to seeing the clinician. Deductible amounts may be collected prior to the clinician 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 clinician, caused an adverse reaction. A $20.00 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.

Bad Debt Account Status: I realize that if my account is in bad debt I may be required to pay a **down payment** of $150.00 prior to my scheduled appointment. Forefront has the right to apply the down payment to any outstanding balance or bad debt balance first. 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.

Medicaid Affidavit *(ALL patients must answer):*
At this time I represent and warrant that the patient (DOES) or (DOES NOT) have ***Medicaid coverage***.
(Circle One - if unmarked, default is a representation that the patient does not have Medicaid currently. If you are completing this form on a system where you cannot circle one, please inform the staff immediately if the patient has 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 clinicians 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 clinician on the date of service. This is not considered payment in full. The down payments are determined by the individual clinic based on local considerations and will be at least 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 clinician sees the patient and a complete assessment is made. The clinician may require payment in full for procedural services prior to rendering such a service and/or may require payment in full for all services on the date of the visit.

Procedure Pricing: I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment unless otherwise required by law.

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 messages 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. Confidential information will be treated in accordance with HIPAA and applicable state law.

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 or an appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, and billing and collection information. 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.

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

Open Payments Database Notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

The undersigned hereby agrees to these terms as the patient or legal representative of the above referenced patient if the patient does not have the legal capacity to agree (for example: minors under the age of 18 (19 in the state of Alabama) or incapacitated patients with an active power of attorney).

_____ _____ until revoked
Signature of Patient or Legal Representative **Date**

_____
Relationship to Patient

Effective: 3/1/2025

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Consent to Clinical Procedures

Patient Name (PLEASE PRINT): _____ **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 clinician. This may include, but is not limited to, laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatments or procedures (including wart treatments, lesion destructions, surgical removals, or excisions), or other services rendered during my visit with Forefront Dermatology, S.C. or its affiliated practices ("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 their being performed. Our dermatology clinicians 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.

With the automatic release of test results to your electronic medical record, it is possible that you will see results in your record before your physician or other clinician. Your treating clinician is trained to interpret your results based on your specific medical history and condition, and to reach a proper diagnosis and develop a proper treatment plan. I understand that, to avoid unnecessary concern, I am encouraged to speak with my clinician about any new concerning results.

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.
- Discoloration – pigment producing cells of the skin are sensitive, and darkening or lightening of the skin may occur with any procedure.
- 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 cause bleeding. Significant bleeding is rare, but some patients are at increased risk of post-operative bleeding that may require additional intervention.
- Nerve damage – This will be discussed with you by your clinician if it is a known risk of your procedure.

Forefront is committed to creating a safe environment for all patients and understands that the relationship between the clinician and the patient requires a high level of trust and professional responsibility. It also requires interactions that at times can involve sensitive physical examinations. To protect you and your clinician it is Forefront's policy that a chaperone or other third party be present for all sensitive medical examinations. The chaperone or third party is a member of our staff who serves as a reassuring presence for you and your clinician during your exam or procedure at no additional cost to you. I understand that I may opt out of having a chaperone or third party present for certain examinations or procedures and that the clinician may decline to examine or treat me at their discretion if a chaperone or third party is not present. I acknowledge that I can speak to a staff member or my clinician if I have questions or concerns.

The person providing some or all of your treatment may be acting under supervision and delegation of a licensed physician, physician assistant, or nurse practitioner ("Licensed Clinician"). Some state scope of practice laws require an assessment by a Licensed Clinician be performed prior to receiving certain medical or cosmetic procedures. Such laws allow these procedures to be performed by an assistant under delegation and supervision of the Licensed Clinician. Such person is acting in the capacity of a medical assistant when performing the service, regardless of whether they have other credentials or licenses (e.g. licensed esthetician). If you have any questions, please discuss with your Licensed Clinician.

I authorize pictures to be taken before, during and after procedures. 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.

Assignment of Benefits / Insurance Filing: 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. If the clinician treating you is not contracted with your insurance plan, we will bill your insurance plan for charges incurred at our clinic as a courtesy to you. Please remember that your health insurance is a contract between you and your insurance plan. We will furnish information required by the insurance plan to receive payment. Our office will make an attempt to settle any outstanding bill with your insurance plan. You agree to be responsible for the balance of the costs of the services provided to you that are not reimbursed by your insurance plan. Benefits should be paid directly to the Practice from your insurance plan. If your insurance plan reimburses you directly for any outstanding amounts due to us, payment will be expected by us within 10 days. If the clinician treating you is contracted with your insurance plan, we will furnish information required by the insurance plan to receive payment. 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 to the extent permitted by applicable law and insurance plan contracts.

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 clinician prior to any procedure and therefore, with my signature, agree to have any necessary procedures performed. If I would like to withdraw my consent at any time I will notify Forefront in writing.

The undersigned hereby provides consents as the patient or legal representative of the above referenced patient if the patient does not have the legal capacity to consent (for example: minors under the age of 18 (19 in the state of Alabama) or incapacitated patients with an active power of attorney).

Signature of Patient or Legal Representative _____ **Date** _____

Relationship to Patient _____

Effective: 3/1/2025

HealthySkin History and Intake Form

Name: _____ Date of Birth: _____ Height: _____ Weight:_____

Occupation: **Hobbies:**

If you are a new patient, how were you referred to us? _____

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

Atrial fibrillation	Hepatitis B	Hyperthyroidism	Pacemaker	Seizures
Anxiety	Hepatitis C	Hypothyroidism	Defibrillator	Radiation Treatment
Diabetes	HIV/AIDS	Heart Attack	COPD	Rheumatoid Arthritis
End Stage Renal Disease	Hypertension	Stroke	Hearing Loss	GERD
Depression	Asthma	High Cholesterol	BPH	Coronary Artery Disease

History of Cancer (Other Than Skin Cancer): _____ None

Do you have any issues with: (*Please circle all that apply)* Healing Bleeding Scarring Immunosuppression

Do you have any allergies/sensitivities to the following? : Adhesives Latex Lidocaine Epinephrine Neosporin/Bacitracin

YOUR Skin Disease History: *(Please circle all that apply*)

Basal Cell Skin Cancer Precancerous Spots/Moles Actinic Keratoses

Squamous Cell Skin Cancer Melanoma - Location:_____ Year:_____

YOUR FAMILY History of Skin Disease: *(Please circle all that apply)*

Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma Yes, skin cancer type unknown

If you do have family history, which family member? _____

Do you wear sunscreen? Yes No **Do you tan in a tanning salon? Yes No Not anymore**

If yes, what SPF? _____

Past Surgical History: *(Please circle all that apply)*

Heart Valve Replacement Joint Replacement - Site and year:_____

Coronary Artery Bypass Organ or Bone Marrow Transplant:_____

Please list additional surgeries and their approximate date: _____

_____

Females Only, Are You: Pregnant Breastfeeding

Medications: *Please list all current medications/vitamins/herbs, including the dosage, how often you take them, and how (ex: by mouth, etc). If more space is required, please see our Front Desk for a separate Medication Form.*

_____

_____

_____

Allergies: *Please list all allergies and the reaction you experience to each.*

_____

_____

Cigarette Smoking:	**Alcohol Use:**		**Substance Abuse:**
Never smoked	Yes	# of Drinks Per Day:_____	Yes
Quit: former smoker	No		No
Smokes less than daily			
Smokes daily			

Is it ok to leave a detailed message with anyone else? No Yes If so, with whom?_____

Pharmacy: _____ **Cross Streets:** _____

Zip code: _____ _____

HEALTHYSKIN DERMATOLOGY MEDICAL & COSMETIC

Authorization to Release Health Information

The confidentiality of your health information is very important to us. We recognize that you may want certain family, close friends or caregivers to have access to your medical records. Please list the names, relationship to you, and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information, test results, medication, problem and allergy lists. If you have a durable health care power of attorney, please provide a copy of this document to our office as well.

Patient/Representative may revoke or modify this specific authorization at any time, and that revocation or modification must be in writing.

I, _____, hereby give my permission for my physician's office, Sheftel & Associates Dermatology, LLP dba HealthySkin Medical & Cosmetic Dermatology, to disclose my Protected Health Information for purposes of communicating my medical condition, to communicate results, findings and care decisions, medication, problem, and allergy lists, appointments, billing information, and/or any other relevant information to (*please print*):

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Please note: we cannot share your Protected Health Information with any family, friends, or caregivers unless their name is listed on this sheet. Please be sure to list all persons you would like to give permission for us to disclose your Protected Health Information to above.

By signing below, I am giving my permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the person(s) listed above. *I am also acknowledging it is my responsibility to notify HealthySkin Medical and Cosmetic Dermatology of* ***any*** *changes to the communication permissions I have given in this document, in writing, as soon as possible.*

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient Signature Today's Date

_____ _____
If patient is a minor, parent or legal guardian's signature Today's Date

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To be completed by HealthySkin Medical & Cosmetic Dermatology Staff:

_____ Note entered in chart
(staff initials)

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)