Patient Information

Please Print

Name_____
Last Name First Name MI

SS#_____Date of Birth_____ Age____ Sex____

Address_____ City_____ St_____ Zip_____

Race_____Preferred Language_____ ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Married ☐ Not Married

Primary Phone( )_____-_____Alt Phone( )____-_____E-Mail _____

Spouse or parent name if patient is a minor _____

Emergency Contact _____Relationship_____Phone( )____-_____

Do you have a referring doctor for this visit? If so, who_____

Does office have permission to discuss medical information with anyone else? ☐ Yes ☐ No

If yes, please provide their information:

Name _____ Relationship_____Phone ( )____-_____

Insurance Information

Primary Policy Holder Information

If Different than Patient's Information

Insurance Company: _____ Name_____

Date of Birth_____ Employer_____Relationship to Patient_____

Address_____City_____State___Zip_____Phone( )____-_____

Secondary Policy Holder Information

If Different than Primary Policy Holder Information

Insurance Company: _____ Name_____

Date of Birth_____Employer_____Relationship to Patient_____

Address_____City_____State___Zip_____Phone( )____-_____

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Patient Name: _____

Date of Birth: _____

Occupation: _____

Place of Employment: _____

Primary Doctor: _____

Pharmacy: _____

Race: _____

Please check one:

Tobacco use:
- □ Current
- □ Former
- □ Never

Alcohol use:
- □ Daily
- □ Weekly
- □ Monthly
- □ Socially
- □ Never

For female patients:

Are you pregnant?
- □ Yes
- □ No

Medical History: (Please check all that apply)
- □ Actinic Keratosis
- □ Allergies
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Blood Clots
- □ Communicable Diseases: _____
- □ Cancers Type: _____
- □ Congestive Heart Failure
- □ Depression
- □ Diabetes
- □ Eczema
- □ Gastrointestinal Disease
- □ Other: _____
- □ Glaucoma
- □ Hepatitis C
- □ High Cholesterol
- □ High Blood Pressure
- □ Liver Disease
- □ Mental Disorder
- □ Multiple Sclerosis
- □ Phlebitis
- □ Psoriasis
- □ Renal Disease
- □ Rosacea
- □ Seizure Disorder
- □ Thyroid Disease
- □ Tuberculosis

Surgical History: (Please check all that apply)
- □ Defibrillator Year: _____
- □ Organ Transplant Type: _____ Year: _____
- □ Pacemaker Year: _____
- □ Other: _____ Year: _____

Skin Cancer History: (Please check all that apply)
- □ Basal Cell Year & location: _____
- □ Squamous Cell Year & location: _____
- □ Melanoma Year & location: _____

Family medical history: (please check all that apply for mother, father, siblings & extended family)

Skin Cancer
- □ Basal Cell
- □ Squamous Cell
- □ Melanoma
- □ Eczema
- □ Psoriasis
- □ Dermatitis

List of current medications: (Prescription, over the counter and as needed)

**** (IF YOU HAVE A LIST OF MEDICATIONS, WE CAN COPY IT FOR YOU TO ATTACH TO YOUR HISTORY FORM) ****

List of allergies:

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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 Heartland 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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Patient Communication & Financial Policies

The Following are internal policies set in place by the administration of Forefront Dermatology, S.C., d/b/a Heartland 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:*_____

Updated 5/14/2018

Heartland Dermatology
A FOREFRONT DERMATOLOGY PRACTICE

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., d/b/a Heartland Dermatology ("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 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 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***

Updated 6/11/2018