PATIENT INFORMATION

DEMOGRAPHICS

LAST NAME FIRST M.I. AGE DOB SSN or LAST 4

ADDRESS CITY/STATE/ZIP

HOME PHONE CELL PHONE WORK PHONE M F GENDER (circle one)

EMPLOYER OCCUPATION EMAIL

WHO REFERRED YOU ☐ DERMATOLOGIST ____________ ☐ PCP/PHYSICIAN ___________
☐Internet ☐FRIEND/FAMILY ______________ ☐ BUSINESS/INSURANCE __________

PRIMARY CARE PROVIDER (PCP) PCP CITY PHARMACY NAME & LOCATION

EMERGENCY CONTACT: NAME, RELATION & PHONE NUMBER Advanced Care Plan: YES OR NO

OKAY TO LEAVE DETAILED MESSAGE?: YES or NO

CONSENTS - Please read the following and sign below.

Notice of Health Information Practice: I have read and understand the Notice for Health Information Practice and I acknowledge that the Notice of Swann Dermatology Privacy Practices is on file and I may access it any time.

Consent to Share Medical Information with Others: I authorize Swann Dermatology Partners and staff to share my healthcare information with the following people. Please understand that if a person is not listed that we can not discuss any medical information with them, no matter their relationship to you.

Y N
Name Relationship Phone Ok to Leave Detailed Message

Y N
Name Relationship Phone Ok to Leave Detailed Message

SIGNATURE OF PATIENT DATE

SIGNATURE OF PARENT/GUARDIAN DATE

SWANN DERMATOLOGY PARTNERS

A FOREFRONT **DERMATOLOGY** PRACTICE

PATIENT HEALTH QUESTIONNAIRE

What is the primary reason for today's visit? (Chief Complaint) ______________________________

Today's Date

Have you ever had skin cancer? Yes No What type? ______________ When? ____________

Current medical conditions (check any) ____ Hepatitis ____ Leukemia _____Cancer _________(type)

____ Anxiety ____ Diabetes ____ Hypertension ____ Lymphoma ____ Seizures ____ Atrial Fibrillation
____ Kidney Disease ____ HIV ____ AIDS ____ Radiation ____Strokes ____ Incontinence

Past surgeries (check any & write year) ____ Gallbladder ____ Kidney ____ Skin: Basal Cell
____ Appendix ____ Breast ____ Heart ____ Liver ____ Bladder ____ Skin: Squamous Cell ____ Colon
____ Joint ____ Prostate ____ Melanoma

____

ADDITIONAL PAST SURGERY DETAILS

Skin History (check any) ____ Hay Fever/Allergies ____ Poison Ivy ____ Rosacea ____ Acne
____ Bad Sunburns ____ Flaking Scalp ____ Atypical Moles ____ Wear Sunscreen ____ Dry Skin
____Psoriasis ____ Used Tanning Beds ____ Eczema _____ Actinic Keratoses ____ Other

____

ADDITIONAL SKIN HISTORY DETAILS

Family History of Melanoma? Yes No Which Relative? ______________________________

Are you up to date on the Flu vaccine? Yes No
Are you up to date on COVID vaccine? Yes No

Skin Medications: ____

ALL Medications: ____

Blood Thinners: Yes No (Circle) Aspirin/ Coumadin/ Plavix/Xarelto/Pradaxa/Eliquis/Vitamin E/Fish Oil/Garlic

Drug Allergies: ____

Smoking Status: ___ Never smoked ___ Former Smoker ___ Current Smoker ________ Packs per day

Alcohol use: ___ Yes ___ No ___ Amount

Reviews of Systems (check any) ___ Fever or Chills ___ Headaches ___ Problems Hearing ___ Blurry Vision ___ Yeast Infections after antibiotics ___ Abdominal Pain ___ Joint Aches ___ Night Sweats ___ Neck Stiffness ___ GI upset with antibiotics ___ Problems Healing ___ Pregnancy ___ Muscle Weakness ___ Organ Transplant ___ Immunosuppression ___ Pacemaker (year placed: _______) ____ Joint Replacement ____ Artificial heart valve

Any other details you think we should know about your health:

FOREFRONT DERMATOLOGY® AND AFFILIATED PRACTICES

NOTICE OF PRIVACY PRACTICES

Effective 1/31/2026

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.

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.

Substance Use Disorder Treatment Information
If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. HIPAA-covered entities and business associates which receive PHI including Part 2 records for treatment, payment, or health care operations purposes may redisclose your records in accordance with HIPAA regulations. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us, or in accordance with a court order.

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.

Our use and disclosure of certain sensitive information may also be further restricted by other federal or state laws. This includes information related to genetics, behavioral health, and HIV/AIDS.

State law may provide additional privacy protections or reporting obligations for reproductive health information. When state law is more protective than federal law, we follow state law; when state law requires reporting or disclosure, we comply only as allowed by the HIPAA Privacy Rule and other applicable law.

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.

- **Access 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.

  You have the right to access your electronic health information in accordance with applicable laws.

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

Health Information Exchanges (HIEs)

Forefront Dermatology may participate in various initiatives to facilitate electronic sharing of patient information, including but not limited to Health Information Exchanges (HIEs). An HIE 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. Making your information available through an HIE is not a condition of receiving care. You may opt out of electronic sharing of information through our HIE activities by contacting the Privacy Office at the contact information below.

1/Please note that if you choose to opt out after your information has been shared through an HIE information that was previously shared will likely still be available if previously accessed by another provider although no new information is shared.

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:

Privacy Officer
Forefront Dermatology
801 York Street
Manitowoc, WI 54220
Phone: 920-663-0505
privacy.officer@forefrontderm.com

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Notice of Privacy Practices Acknowledgement of Receipt

Patient Name: ______________________________ **Date of Birth:** ______________________

By signing this form, you confirm that you have been provided access to Forefront Dermatology's "Notice of Privacy Practices" (the "Notice"). This document explains how we may use and share your personal health information. We recommend reading it carefully.

The Notice may change over time. You can get the latest version on our website at forefrontdermatology.com or by calling us at 855-535-7175.

Forefront may contact you in the following ways unless you tell us not to:

- We may leave confidential messages on your voicemail or answering machine at the phone number(s) you provide, or with someone who answers your phone and can confirm your identity. These messages may include, without limitation, appointment reminders, test results, billing details, or responses to your medical questions. If you're signing this form electronically and can't enter your contact details, we'll use the phone number and email address you've given to our staff for these communications.

Preferred Number ______________________	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Number ______________________	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Email Address ______________________	

- Forefront may contact you by email, text, or postcard if it follows HIPAA rules. You understand that email and text messages may not be secure.
- You agree to receive calls and messages from or on behalf of Forefront Dermatology and its representatives, including automated or recorded voice calls, text messages, and emails, at the phone number(s) or email address you provided. These communications may include appointment reminders, test results, billing updates, and promotional offers. Forefront may be paid directly or indirectly for sending marketing messages. Messaging frequency may vary. Message and data rates may apply. You can opt out of these messages anytime by replying "STOP" or using another easy method. Signing this form is not required to receive treatment or services.
- 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 Sharing: By signing this form, you agree to let Forefront Dermatology share your health information electronically through Health Information Exchanges (HIEs). These secure systems help your healthcare providers access your medical records to give you better care. Your privacy is important, and strong security measures are in place to protect your data. If you don't want to participate, you can opt out by emailing privacy.officer@forefrontderm.com or calling 920-663-0505.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES & COMMUNICATION CONSENT

I confirm that I received and reviewed Forefront's Notice of Privacy Practices and I agree that Forefront may use and share my personal health information as outlined above. If I am signing on behalf of a patient who cannot legally give consent (such as a minor under 18 – or under 19 in Alabama or Nebraska – or someone with a legal guardian), I confirm that I have the authority to do so.

______________________________ ______________________________
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:** ______________

Consent & Signature: You must sign this form before receiving services. Changes to this form are not accepted and will be considered invalid.

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 & Payments:

In-Network Providers: If your clinician is in-network, we'll submit the necessary paperwork to your insurance.

Out-of-Network Providers: If your clinician is not in-network, we'll still bill your insurance as a courtesy. You're responsible for any unpaid balance.

If your insurance pays you directly, you must pay Forefront within 10 days. If your insurance deems a service to not be 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.

Payment Requirements:

Co-pays, co-insurance, and deductibles are due **before** your appointment.

Cosmetic procedures must be paid in full before treatment. Cosmetic products are **non-refundable**, unless defective or causing an unanticipated reaction.

A **$20 fee** applies for bounced payments. If your account goes to collections, you'll be responsible for legal and collection fees. Your visits may become public record.

Bad Debt Accounts: If your account is in bad debt, you may need to pay **$150 upfront** before your next appointment. This payment may be used to cover any outstanding balance. **This rule does **not** apply to patients with **Medicaid** or those under **bankruptcy 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)

Important Insurance & Medicaid Information

If we later find that the information you gave us wasn't accurate, you'll be responsible for any charges that weren't covered. If you get Medicaid coverage after your visit, it's your responsibility to let us know. If you don't update us, you may have to pay the full bill.

Please note: Not all Forefront locations or clinicians accept Medicaid. If you receive care at a location or from a provider that doesn't participate in Medicaid, you'll be responsible for the full cost of your visit.

For Patients Without Insurance: If you don't have insurance, you'll need to pay a down payment before seeing a clinician. This is not the full cost of your visit. The final amount will be determined after your appointment. The down payments are determined by the individual clinic based on local considerations and will be as follows:

Minimum Down Payments: **New Patient Visit:** $178 **Established Patient Visit:** $150 **Excision Procedure:** $800 **Mohs Procedure:** $1,000

Your clinician may ask for full payment for procedures before they're done or for all services on the day of your visit.

Procedure Pricing Estimates: If you'd like a cost estimate for a procedure, you must request it in writing before your appointment, unless the law requires otherwise. Verbal estimates are not provided.

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 & Consent Summary: Forefront Dermatology may contact you using the phone number(s) or email address you provide. This may include:

Leaving messages on your voicemail or with someone who answers your phone and can confirm your identity.

Sending emails, text messages, or postcards about appointments, test results, billing, or medical questions you've asked.

These communications will follow HIPAA and state privacy laws.

You also give permission to receive automated calls, texts, and emails from Forefront or its representatives. These may include:

- **Appointment reminders**
- **Lab or pathology results**
- **Billing and payment updates**

By providing your contact information, you agree to receive these messages. You can opt out at any time by replying "STOP" or using another method we provide.

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 Nebraska) or incapacitated patients with an active power of attorney).

______________________ ______________________ until revoked

Signature of Patient or Legal Representative **Date**

____

Relationship to Patient

Effective: 3/1/2026

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Consent to Clinical Procedures

Patient Name (PLEASE PRINT): ______________________________ **Date of Birth:** ______________________

I agree to receive any medical or surgical care that my doctor or clinician thinks is necessary. This may include lab tests (like blood draws or skin biopsies), treatments (such as wart removal or skin surgery), or other services provided during my visit to Forefront Dermatology or its partner clinics.

To help me understand my visit, I understand that I can ask any questions before any procedure is performed. The dermatology team will explain and discuss:

- What the procedure is for and the benefits
- How the procedure will be done
- Other treatment options
- What could happen if I didn't get the treatment
- My right to take back your consent at any time in writing
- Possible risks and side effects
- Any extra costs that may come up

I understand that:

Should a biopsy be performed, or any other procedure in which a section of my skin is removed, the specimen will be sent to a pathology lab for diagnosis, unless otherwise ordered by my clinician. This process may involve additional charges, including special staining or outside consultations.

Test results may appear in my electronic medical record before my clinician reviews them. My clinician will interpret the results based on my medical history and condition. To avoid confusion, I can talk to my clinician about any concerning results.

Some conditions, like warts, may require multiple treatments using different methods. Each visit and procedure will be billed separately.

All procedures carry some risks, which may include:

- **Scarring** – We aim for the best cosmetic result, but scarring is possible and not guaranteed to be avoided.
- **Skin discoloration** – The skin may darken or lighten due to its sensitivity.
- **Infection** – Although procedures are done in clean conditions, infections can still occur.
- **Bleeding** – Some procedures may cause bleeding. While serious bleeding is rare, some patients may need extra care.
- **Nerve damage** – This may be a possible risk or side effect for your procedure. You may discuss any questions you have with your clinician.

As part of its commitment to providing a safe and comfortable clinical environment for all patients, Forefront Dermatology may provide a staff member to chaperone exams involving sensitive areas. These are provided at no extra cost. Patients may choose not to have a chaperone, but in that case, the clinician may decide not to proceed with the exam or treatment. Patients can speak with a staff member or clinician about any questions or concerns.

Someone who helps with my treatment may be working under the supervision of a licensed doctor, physician assistant, or nurse practitioner ("Licensed Clinician"). This assistant is considered a medical assistant during the procedure, even if they have other qualifications (such as a licensed aesthetician). In some states, a Licensed Clinician must first conduct an assessment before certain medical or cosmetic procedures are performed by the assistant under the Licensed Clinician's supervision. Patients with questions can speak to their Licensed Clinician.

Photography Consent: I give permission for photos to be taken before, during, and after my procedures. These images will be part of my medical record and may be shared as allowed by HIPAA, including with my family physician or referring doctor.

Insurance and Billing Agreement: I allow Forefront to claim insurance benefits on my behalf. I'll provide any needed information to confirm my coverage. If my clinician isn't in-network, Forefront will still bill my insurance as a courtesy. I understand that I'm responsible for any costs not covered by my insurance. Payments from insurance should go directly to Forefront. If I receive reimbursement instead, I must pay Forefront within 10 days. If my insurance deems a service to not be covered by my insurance plan, I agree to be responsible for the balance of this service to the extent permitted by applicable law and insurance plan contracts.

If I am signing on behalf of a patient who cannot legally give consent (such as a minor under 18 – or under 19 in Alabama or Nebraska – or someone with a legal guardian), I confirm that I have the authority to do so.

I agree that any legal claim or civil action, including but not limited to a claim for medical malpractice, arising from or related to medical care provided by this practice or its employees, must be filed only in the courts of the county where the service was provided.

By signing this Consent, I understand and agree that Forefront Dermatology may use and share my excess tissue left over after a biopsy or procedure for its educational and research purposes internally and with research partners, including companies, instead of disposal after legally required retention periods, and in accordance with law.

I have read and understand this consent form, including the risks of any procedures I may have during my visits to Forefront. I agree to have any necessary procedures done and understand I can ask questions before they happen. If I decide to withdraw my consent, I will notify Forefront in writing.

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

____
Relationship to Patient

Effective: 3/1/2026