RADIANT DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

NAME _____ **DOB** _____/_____/_____

Male/Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other _____

Address _____

City_____ State_____ Zip Code _____

Primary Phone Number _____ home / cell

Secondary Phone Number _____ home / cell

E-mail address _____

Emergency Contact

Name_____ Phone number _____

Relationship _____

Preferred pharmacy _____

Pharmacy Zip Code _____

Primary Care Physician _____

Location_____

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NAME_____

Patient Medical History

Do you have now, or have you ever had diseases or conditions of (please check if applies):

☐ Anxiety/Depression
☐ Arthritis
☐ Asthma/Wheezing
☐ Irregular Heartbeat
☐ Heart Murmur
☐ Heart Attack
☐ Seizures/Epilepsy/Convulsions
☐ Blood Clots
☐ Bleeding Disorder
☐ Pacemaker
☐ Swelling Hands/Feet
☐ Diabetes
☐ High Blood Pressure
☐ Stroke
☐ Dizzy Spells
☐ Fainting
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Eye Disease

Other:_____

Please list any surgeries in the past 6 months: _____

_____

Skin Disease History

☐ Acne
☐ Precancerous Moles
☐ Actinic Keratoses
☐ Psoriasis
☐ Basal Cell Cancer
☐ Melanoma
☐ Dry Skin
☐ Keloids/Scars after Surgery
☐ Squamous Cell Cancer
☐ Blistering Sunburns
☐ Eczema

Other:_____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No
Family History of Melanoma? ☐ Yes ☐ No Relation: _____

Medications: ☐ NONE
(Please provide name and dosage—if you have a list, we will happily make a copy)

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Allergies: ☐ No Known Drug Allergies
(Please provide causative medication and reaction)

_____

_____

_____

Social History
Do you smoke? ☐ Current ☐ Former ☐ Never If current, how much?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Family Medical History
(parents and siblings only):

_____

_____

_____

How did you hear about Radiant Dermatology?

☐ Doctor:_____ ☐ Friend:_____

☐ Insurance ☐ Internet/Website

☐ Magazine Ad (which one?):_____

☐ Other: _____

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Name _____

Review of Systems: Are you currently experiencing any of the following? If so, please check the corresponding box.

☐ Problems with healing/bleeding
☐ Rash
☐ Hay Fever
☐ Fever/Chills
☐ Unintentional Weight Loss
☐ Sore Throat
☐ Abdominal Pain
☐ Joint Aches
☐ Neck Stiffness
☐ Seizures
☐ Shortness of Breath
☐ Anxiety
☐ Problems with Scarring
☐ Immunosuppression
☐ Chest Pain
☐ Night Sweats
☐ Thyroid Problems
☐ Blurry Vision
☐ Bloody Stool or Urine
☐ Muscle Weakness
☐ Headaches
☐ Cough
☐ Wheezing
☐ Depression

Other symptoms: _____

Alerts:
☐ Allergy to Adhesive
☐ Allergy to Lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Blood thinners
☐ Pregnant (_____wks)
☐ MRSA
☐ Pacemaker
☐ Require antibiotics prior to surgery
☐ Rapid heart beat with epinephrine
☐ Defibrillator
☐ Breastfeeding

RADIANT DERMATOLOGY
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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

RADIANT DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

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

RADIANT DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

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 privacy.officer@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

RADIANT DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

Office Policies

Missed/Cancellation Policy: If you are unable to keep your appointment please notify our office at least 24hours in advance. Failure to provide 24 hour notice will result in a $30 no-show fee, which will need to be collected prior to rescheduling to the extent permitted by law or applicable payor contracts. If the appointment in question is a surgical visit (Excision or Mohs) the fee associated with this type of visit is $250, which will need to be collected prior to rescheduling. No-show charges are not billable to your insurance.

Past due/Bad Debt: Any past due or bad debt on your account will be required to be collected or will need to have a payment plan set in place (available through the billing department) prior to scheduling any future appointments.

Cosmetic Consultation: All cosmetic consultations with Dr. Friedrichs will require $100 deposit due at the time of scheduling an appointment. This deposit will be applied and deducted from the total cost of your cosmetic services. If you miss your appointment or decide not to move forward with the cosmetic service, the fee is non-refundable.

Cosmetic Cancellations: Any treatment may be cancelled and rescheduled without penalty with a minimum of 24hours of advanced notice. We regret to advise that with less than 24 hours' notice, a fee of $100 per hour of treatment time that your procedure was scheduled for will be charged.

Failure to show up for an appointment without notice will result in a no show fee and 50% of the cost of your treatment being charged. Cancellations must be done by telephone and will not be acknowledged by email or text.

Tardiness: Adequate time is scheduled in order to perform your treatments safely and effectively. We strongly encourage you to give our office an advanced notice that you are running late and we will do our best to accommodate. In the event of an extremely tardy arrival, our staff may need to reschedule your appointment to allow enough time for your treatment, in which case a late fee of $30 will be applied.

Cosmetic Services-Payment method: Cash and all major credit cards including Care Credit are acceptable payment methods for cosmetic services (Botox, Dysport and Dermal Fillers). Checks will not be accepted as a form of payment for cosmetic services. In the event there are extenuating circumstances that result in a no show the clinic may make a determination to waive the no-show fee upon proof of same.

_____ _____

Print Name Date of Birth

_____ _____

Signature of patient or guardian Today's Date