INVERNESS
Dermatology & Laser

250 Inverness Center Drive
Hoover, AL 35242
ph 205.995.5575
fax 205.995.5576
www.InvernessDerm.com

New Patient Form

Patient Name:_____ DOB:_____ Date:_____

Sex:_____ Race:_____ Ethnicity: _____ Preferred Language: _____

Social Security #:_____ Driver's License #:_____

Address: _____

City/ State/ Zip: _____

Phone (Primary): _____ (Secondary): _____ Email: _____

May we leave a detailed message on your answering machine or voice mail? ◯ Yes ◯ No

Emergency Contact

Name: _____ Phone: _____ Relationship to Patient : _____

Insurance Information

Primary Insurance:_____ Policy #: _____ Group #: _____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Responsible Party's Name:_____

Secondary Insurance:_____ Policy #:_____ Group #: _____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Primary Care Physician

Primary Care Doctor :_____ Phone Number :_____

Name of Referring Physician(if applicable)_____

If not a consult, how did you hear about our practice?_____

Preferred Pharmacy

Pharmacy Name, location and phone number :_____

What skin problem(s) are we seeing you for today? **Please be aware that, unless scheduled as one, a complete skin exam requires a separate visit to ensure we have the necessary time to be thorough.**_____

_____

To stay up to date on our monthly specials and giveaways, sign up for our newsletter!

YES ◯ NO ◯

Elizabeth Jacobson, MD
Board Certified Dermatologist

Shellie Marks, MD
Board Certified Dermatologist

Katherine Hunt, MD
Board Certified Dermatologist

Mary Beth Templin, PA-C
Physician Assistant - Certified

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Past Medical History: (please check all that apply)

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

Other_____

Past Surgical History : (please check all that apply)

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

Other_____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Asthma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Poison Ivy
- ☐ Psoriasis
- ☐ NONE

Other_____

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Skin Cancer History: (please mark all that apply and write the location(s) and date(s) in the space provided)

□ Actinic Keratoses_____

□ Basal Cell Carcinoma_____

□ Melanoma_____

□ Precancerous Moles_____

□ Squamous Cell Carcinoma_____

□ Other_____

□ NONE

Do you have a family history of Melanoma? Yes ☐ No ☐

If yes, which relative(s)?_____

Medications: (Please enter all current medications) List name, Dose, Frequency

Medication Name	Dose	Frequency

Allergies: (Please enter all DRUG allergies)_____

_____

Social History:

Cigarette Smoking:

□Currently Smokes
□Never smoked
□Former Smoker

Alcohol Use:

□None
□Less than 1 drink per day
□1-2 drinks per day
□3 or more drinks per day

Other_____

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Family Medical History (Only first degree relatives) *INCLUDE ANY SKIN CANCER*

_____

_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Changing Mole	○	○
Rash	○	○
Use of Tanning Bed	○	○
Sunscreen Use	If yes, what SPF	☐
Joint Aches	○	○
Muscle Weakness	○	○
Diarrhea	○	○
Shortness of Breath	○	○
Anxiety	○	○
Depression	○	○
Thyroid Disease	○	○
Fever or Chills	○	○
Nose Bleed	○	○
Headaches	○	○

ALERTS: (please check all that apply)

- ☐ Pacemaker
- ☐ Allergy to lidocaine
- ☐ Defibrillator
- ☐ Artificial joints within the last two years
- ☐ Artificial heart valve
- ☐ Pre-medication prior to procedures
- ☐ Pregnancy or planning a pregnancy
- ☐ Blood thinners
- ☐ History of fainting
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ Organ transplant
- ☐ Breastfeeding

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A FOREFRONT DERMATOLOGY PRACTICE

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Inverness Dermatology, LLC
Patient Contact Information Sheet

Patient Name: _____ Date of Birth: _____

Social Security Number or Driver's License Number (required by HIPAA law): _____

Any physician, staff, employee or representative of Inverness Dermatology, LLC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Inverness Dermatology, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

Insurance Screening Questions

The government has required all medical offices to ask certain screening questions. We appreciate your cooperation. If you have any questions, please do not hesitate to ask.

Vaccinations:

Any age: Have you had a flu shot in the past 12 months? **YES** ☐ **NO** ☐

As medical professionals, we recommend patients of all ages be vaccinated every year

Over 65 years: Have you had a pneumonia vaccine? **YES** ☐ **NO** ☐

Tobacco:

Over 14 years: Do you smoke? **YES*** ☐ **NO** ☐

*If yes, how many packs per day? And how many years? _____packs per day, _____ years

*If you answered YES to the tobacco questions, we recommend quitting.
You can ask any health care provider about resources to help you in this process, some of which are listed below.
https://smokefree.gov/ or https://www.cdc.gov/tobacco/quit_smoking/how_to_quit/resources/

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Consent to Clinical Procedures

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

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my visit with Forefront Dermatology, S.C. or its affiliated practice ("Forefront").

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen <u>will be</u> sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges.

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly.

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your provider if it is a potential during your procedure.

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

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

Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Forefront. I do not impose any limitations on Forefront and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

_____

Patient signature / Date

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian signature/ Date ***Relationship to Patient***

Updated 6/4/2020

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

Patient Name (PLEASE PRINT) _____ **Date of Birth** _____

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our practice at 855-535-7175.

Please note that Forefront may communicate with you in the following ways, unless you instruct us otherwise:

- In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff. If you are signing this form via an electronic method which does not allow you to provide your preferred phone number and email address above, these communication policies shall apply to the phone numbers and email addresses you provide to Forefront staff for the above stated purpose.

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

- Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.
- You specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront and its representatives at the number(s) provided above or an appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, billing and collection information and marketing or advertising messages offering products or services that may be of interest to you. Forefront may receive direct or indirect payment for these marketing messages. You understand that by providing your telephone number and/or e-mail address to Forefront, you consent to being contacted using the above-described methods. If you receive communications from Forefront, you will be given the opportunity to opt-out of future communications by responding "STOP" or through another easily used mechanism, should you make that choice. You understand that you are not required to sign this agreement in order to receive treatment and that your consent is not a condition of purchasing or using any services offered by Forefront.
- If you have any questions about our Notice, please contact our compliance department – Phone: 920-663-0505, e-mail: compliance@forefrontderm.com

I acknowledge receipt of Forefront's Notice of Privacy Practices. I understand and agree to how Forefront may communicate with me, as stated above.

X _____ _____

(Signature of Patient or Legal Representative) **Date**

Parents may not sign for children over the age of 18 (or 19 years of age in Alabama).

If signed by someone other than patient, indicate relationship: _____

Print name _____

(Legal representative)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

Reasons why the acknowledgement was not obtained:

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

☐ Other _____

_____ _____

Employee Name Date

Updated 5/22/19

FOREFRONT DERMATOLOGY
AND AFFILIATED PRACTICES

Patient Communication & Financial Policies

The following are internal policies set in place by Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Signature is required before services can be provided.

Patient Communications: In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.

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

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. If your insurance deems a service to be not covered by your insurance plan you agree to be responsible for the balance of this service. Claims not paid by your insurance carrier within 90 days will be considered a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the Practice from your insurance company. If your insurance company reimburses you directly for any outstanding amounts due to us, payment will be expected by us within 10 days. I hereby assign to Forefront all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Bad Debt Account Status: I realize that if my account is in bad debt I will be required to pay a **down payment** of $150.00 prior to my scheduled appointment. In the event that this down payment exceeds the visit cost, the overpayment will first be applied towards any outstanding balance or bad debt balance and any remaining balance will be refunded to you. I realize that if my account is sent to collections, Forefront may also elect to dismiss me as a patient from the practice. If I pay off my bad debt account, my account will be returned to good standing status and I will not be required to make a down payment on future visits unless I am placed into collections again in the future. This provision does not apply to patients who currently have Medicaid health insurance coverage or to patients who are currently under bankruptcy or any other insolvency protection.

Financial Responsibility: A $35.00 charge will be added for any non-sufficient funds notice from the bank. I understand and agree that I will be responsible for all legal fees and other costs of collection if my account is turned over to an attorney or agency for collection in which case your visit/s with our office may become a matter of public record.

Medicaid Affidavit:

ALL patients must answer →

At this time I,_____ represent and warrant that I
(Print Your Name)

(DO) or (DO NOT) have ***Medicaid coverage***.

***(Circle One** - if unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot circle one, please inform the staff immediately if you have Medicaid health insurance coverage)*

If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office you may be responsible for the balance of your bill. Not all locations and providers participate in Medicaid programs. The patient will be responsible for the full amount of services provided when this circumstance is applicable.

Non-insured Patients: Non-insured patients will be charged a **down payment** prior to seeing a provider on the date of service. This is not considered payment in full. The down payments are as follows:

- New patient Office Visit: $178
- Established Patient Office Visit: $150
- Excision Visit: $800
- MOHS Visit: $1,000

Final charges will be determined after the provider sees the patient and a complete assessment is made. The provider may require payment in full for procedural services prior to rendering such a service. If the balance is paid in full within two weeks from the date of the statement, a 20% discount for cash/check or a 15% discount for credit card will apply. ***This discount does not apply to Cosmetic procedures and injectables.***

Co-payments, Co-insurance, Deductible, & Cosmetic Procedures: Payment is due on the date of service prior to seeing the provider. Deductible amounts may be collected prior to the provider completing the service. Payment for a cosmetic procedure is due in full prior to treatment. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction.

Procedure Pricing

I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment.

X _____ _____ ____/____/____until revoked
Signature of Patient or Legal Representative *Date of Birth* *Date*

_____ *Relationship to Patient*

Updated 5/22/19