INVERNESS
DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

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: _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

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

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

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

## Primary Care Physician

Primary Care Doctor : _____ Phone Number : _____

Name of Referring Physician( if applicable) _____

## 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** ◯

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**Past Medical History:** (please check all that apply)

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Elevated Blood Pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Hearing Loss
- ☐ High Cholestrol
- ☐ HIV
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of the Liver
- ☐ Malignancy/Cancer:

  _____
- ☐ Transplantation ofBone Marrow
- ☐ NONE

Other_____

**Past Surgical History :** (please check all that apply)

- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Coronary Artery Bypass Graft Entire
- ☐ Transplanted Kidney
- ☐ H/O: Colostomy
- ☐ H/O: Tubal Ligation
- ☐ H/O: Appendectomy (Appendix)
- ☐ H/O:Cholecystectomy (Gallbladder)
- ☐ H/O: Colectomy:
- ☐ H/O: Liver Excision
- ☐ Total Cystectomy
- ☐ H/O: Transurethral Prostatectomy (TURP)
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Lumpectomy of Breast (Left, Right or Both)
- ☐ Mastectomy (Left, Right or Both)
- ☐ Mechanical Heart Valve Replacement
- ☐ Oophorectomy (Ovaries Removed)
- ☐ Pancreatectomy (Pancreas Removed)
- ☐ Prostatectomy (Prostate Removed)
- ☐ Splenectomy (Spleen Removed)
- ☐ Total Nephrectomy (Kidney Removed)
- ☐ Total Orchidectomy (Testes Removed)
- ☐ Total Hip Replacement (Left, Right or Both)
- ☐ Total Knee Replacement (Left, Right or Both)
- ☐ Transplant of Heart
- ☐ Transplant of Liver
- ☐ 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 wear sunscreen? Yes ☐ No ☐ If yes, what SPF?_____

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

If yes, which relative(s)?_____

Do you have a family history of Basal or Squamous Cell? 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

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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 | ○ | ○ |
| Joint Aches | ○ | ○ |
| Muscle Weakness | ○ | ○ |
| Anxiety | ○ | ○ |
| Depression | ○ | ○ |
| Thyroid Disease | ○ | ○ |
| Fever or Chills | ○ | ○ |

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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# Inverness Dermatology& Laser
# 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.*

**Age 12-13**: To the best of your memory, has the patient received their meningitis and Tdap shots and the full series of HPV immunizations? ☐ **YES** ☐ **NO**

**Tobacco:**
**Over 12 years**: Do you smoke? **YES*** ☐ **NO** ☐ *If yes, _____packs per day, _____ years

**Advance Care Plan, Age 65+**
**Ages 65+:** Do you have a health care proxy in the event you are unable to make your own medical decision? **YES** ☐ **NO** ☐

*Advance care planning is the process of making arrangements for future medical care.*
*A health care proxy or surrogate is a designee appointed to make medical choices as well as arrangements for end-of-life care on behalf of the patient when the patient is incapacitated or lacks the ability to make their own medical decisions.*

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®
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# 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**

# Minor Patient Consent Form

Patient's Name: _____ Patient's Date of Birth: _____/_____/_____

**All minors must be accompanied by a parent or a legal guardian for their first visit with our practice.** Unfortunately, due to informed consent and contracting laws, we cannot treat your child for a new condition until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child can only be evaluated, and only if a parent or legal guardian consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a parent or legal guardian after receiving the appropriate information.**

1. **Evaluation authorization** by parent/legal guardian only: *Check one box only*

☐ I will be attending all appointments with my minor child and do not want my minor child evaluated unless I am present.

☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to authorize any additional treatments, my minor child will need to come back for additional treatment after I provide the necessary authorization and consent.

2. **Treatment authorization** by parent/legal guardian only: *Check one box only*

☐ I will be attending all appointments with my minor child and will be present to give consent if a procedure is recommended. You may not treat my minor child without my authorization and approval at the time of treatment.

☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for ongoing care of any previously diagnosed condition for which I have already provided informed consent.

3. **Insurance information:**

If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification tothe receptionist.

If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____/_____/_____
Parent/Guardian's Relationship to Patient: _____

4. **Payment Policy:**

The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court ruling or divorce decrees. We will only respond to a court order that directs Forefront Dermatology to act in a certain way.

**Guardian Signature:** _____ **Today's Date:** _____/_____/_____

5. **Parent/Guardian Contact Information:**

**Father**/Guardian: First Name _____ Last Name_____

**Phone (8am-5pm)** _____ ☐ Home ☐ Work ☐ Cell (choose one)
2nd Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)

**Mother**/Guardian: First Name _____ Last Name_____

**Phone (8am-5pm)** _____ ☐ Home ☐ Work ☐ Cell (choose one)
2nd Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

## NO SHOW POLICY

At Forefront Dermatology, we pride ourselves in providing our patients with quality unparalleled customer service. Many patients may wait weeks to months for an appointment to see our providers and we are disappointed to not be able to help them sooner. Failure to show for a scheduled appointment or canceling in an untimely fashion is discourteous to fellow patients, as there are other patients in need of your appointment.

**Missed Appointments:**

If you are unable to keep your appointment please notify our office at least 24 hours prior to your appointment time. Failure to provide 24 hours' notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is $50 for a medical office visit and $250 for a surgical visit or cosmetic procedure. No-show charges are not billable to your insurance.

If a patient no-shows two times within a 365-day period this may result in the patient being put in a no-show status. Such patient will not be able to call to schedule an appointment but instead will be directed to walk into the clinic and wait for an opening if one is available. Once you are seen in clinic as a walk-in patient, you will be removed from the no-show status.

I understand and agree that if I fail to provide notification of my intent not to keep my scheduled appointment at least 24 hours in advance of that appointment, I will be charged for the scheduled time. I understand I am solely responsible for this missed appointment.

In the event there are extenuating circumstances that result in a no show (e.g. COVID, flu, other contagious illness), the clinic may make a determination to waive the no-show fee upon proof of same.

I am 18 years of age (or 19 years of age in Alabama) or I have parental/guardian consent below.

**PATIENT OR, IF APPLICABLE, PARENT / LEGAL GUARDIAN* APPROVAL (sign below)**

| Name (print) | Signature | Date |
|---|---|---|
| Witness Name (print) | Witness Signature | Date |

*If this form is executed by a parent or legal guardian, references to words like "my" or "I" contained herein shall be deemed to refer to the patient when appropriate and to the parent/guardian as applicable.

**Nondiscrimination Statement: Discrimination is Against the Law**

Forefront Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Forefront Dermatology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Forefront Dermatology:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Forefront's Civil Rights Coordinator at 920-663-0505.

If you believe that Forefront Dermatology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator c/o Forefront Dermatology, Compliance Department, 801 York Street Manitowoc WI 54220, 920-663-0505, compliance@forefrontderm.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Forefront's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Forefront Dermatology's website: https://forefrontdermatology.com.