FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

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 <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.

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**

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Relationship to Patient

Effective: 3/1/2025