FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

NOTICE OF PRIVACY PRACTICES

Effective 4/23/2021

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.

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.

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.

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.

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 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 compliance@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

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 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

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

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

FOREFRONT DERMATOLOGY®

Authorization for Disclosure of Health Information

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Information:

_____

Name Address City State Zip

Date of Birth: ____/_____/_____ Phone Number _____Previous Name _____

Authorizes:

_____

Name of Health Care Provider / Plan / Other Address City State Zip

Phone Number _____ Fax Number _____

To Disclose To:

☐ **Self** *Delivery Options:* ☐ Pick Up ☐ Mail to Address Above ☐ Email to me (address): _____

☐ **To be picked up by**, I hereby authorize _____to pick up my records. (Photo ID required.)

☐ **Send to:** Name of Health Care Provider / Plan / Other_____

☐ By Mail (Address) _____

☐ By Fax (To #) _____ ☐ By Email (Address) _____

Information to be released:

☐ Office Visit Records ☐ Diagnostic Test Results ☐ Operative Reports
☐ Other Describe: _____

Release records from the time period of _____ to _____ ***If left blank, only the past (2) years will be disclosed.***

Unless checked or listed below, I understand that the following information may be released (as defined by applicable state and federal laws).
Check and/or list if you do *not* want to disclose: ☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities
☐ Genetic Testing/Counseling ☐ Other_____

Expiration:

This authorization is valid for _____ (Maximum of ONE year. If left blank, authorization will expire in one year from the date signed.)

Purpose(s) of the disclosure:

(check all that apply) ☐ Continued Care ☐ Insurance ☐ Legal ☐ Disability Determination
☐ Second Opinion ☐ Personal ☐ Other Describe: _____

Your Rights with Respect to this Authorization:

I understand that I have a right to inspect and receive a copy of the material to be disclosed. I understand that written notification is necessary to revoke this authorization, except to the extent that information may have been released before receipt of this notice. My decision to sign this authorization will not affect my treatment. If this information is being disclosed to an individual or entity that is not a health care provider or health plan, it may be subject to re-disclosure and no longer protected. A photocopy/facsimile or scanned copy of this form is valid as the original.

_____ _____

Signature of Patient / Legal Representative Date
(Form MUST be completed before signing)

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ A Minor ☐ Legally incompetent or incapacitated ☐ Deceased
2. Legal authority: ☐ Parent ☐ Legal guardian ☐ Next of kin/executor of deceased ☐ Activated POA for Health Care

*By signing above, I hereby declare that I have not been denied physical placement of this child.

Please return this completed form in person to any Forefront location, via fax to 920-328-9697 or email to: patientrecordrequests@forefrontderm.com

Updated 10/24/2022

For Office Use Only:

Signature Verified ☐ *Yes* ☐ *No*

Completed by: *Date:*

_____ _____

# of pages released: _____

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Incapacitated Patient Consent Form

Patient's name: _____ **Patient's date of birth:** _____/_____ /_____

It is always desirable and recommended that a legal guardian/ Durable Power of Attorney (DPOA) attend an incapacitated patient's appointment. Unfortunately, due to informed consent and contracting laws, we cannot treat the incapacitated patient until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. **If a legal guardian/DPOA is not present at the time of an incapacitated patient's appointment, the patient can only be evaluated, and only if a legal guardian/DPOA 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 legal guardian/DPOA after receiving the appropriate information.**

1. **Evaluation authorization** by legal guardian/DPOA only: ***(Check one box only)***

☐ I will be attending all appointments with the incapacitated patient and do not want the incapacitated patient evaluated unless I am present.

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

2. **Treatment authorization** by legal guardian/DPOA only: ***(Check one box only)***

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

☐ I will not be attending follow up appointment(s) with the incapacitated patient and give consent for and approval for ongoing care of any previously diagnosed conditions for which I have already provided authorization.

3. Insurance information:

If you ***are*** attending the appointment with the incapacitated patient, please present the insurance card(s) and photo identification to the receptionist.

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

Name of guardian/DPOA: _____ Guardian's/DPOA's date of birth: _____/_____/_____

Guardian's/DPOA's relationship to patient: _____

4. Payment Policy:

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

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

5. Guardian's/DPOA's Contact information:

Guardian/DPOA (please print): First name _____ Last name _____

Phone (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)

Secondary # (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)

6. **Copy of DPOA Obtained:** ☐ Yes ☐ No

This consent must be signed in addition to obtaining a DPOA.

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

CHANGE OF CONTACT INFORMATION

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

By signing this form, you acknowledge that you previously signed a document expressly consenting to Forefront Dermatology, S.C., or its representatives contacting you for a variety of reasons by a variety of methods at the contact points you voluntarily provided. You have decided to change your preferred contact information as set forth below. You agree that Forefront Dermatology may continue to contact you, as previously agreed, at the new contact information voluntarily provided below.

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

X _____ _____

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

Parents may not sign for children over the age of 18.

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

Print name _____
(Legal representative)

AFTER SURGERY CARE INSTRUCTIONS

William S. Farmer, MD

Night of Surgery

- **Rest and Relaxation**: After surgery, rest is crucial. Relax both mentally and physically to keep blood pressure and bleeding under control. Avoid analyzing the results or researching online—trust the process and allow your body to heal.

- **Movement**: To prevent blood clots, periodically move your legs and ankles while resting, and take slow, gentle walks around the room with assistance.

- **Cold Compresses**: Apply a cold compress (e.g., frozen peas, ice pack) to the surgical site for 20 minutes on and 20 minutes off during waking hours, as much as tolerated. Wrap it in a towel or cloth to prevent frostbite. This is most effective during the first three days to reduce swelling.

- **Sleep**: If possible slightly elevate the surgical site above heart level while sleeping to reduce swelling. Continue this for one to two weeks as needed.

- **Hydration**: Drink plenty of water daily to support the healing process.

- **Bathing**: Keep the bandage away from water until it is time to be removed in 48 hours; however, you may get the rest of you wet.

Wound Care

- **Bandage Removal**: **Do not remove your bandage until 2:00 PM, 48 hours after surgery.** If the bandage accidently comes off before then, rebandage the wound. To minimize discomfort, soak the bandage with lukewarm water for 15 minutes to loosen the adhesive before removing it. You may get the wound wet from here on out. The wound may appear swollen, discolored, or dirty; this is normal and not indicative of the final result.

- **Daily Wound Care**: Wash your hands thoroughly before handling the wound. Gently cleanse the wound with lukewarm water for 5 minutes. Do not scrub or rub the site. Apply a thick layer of the prescribed antibiotic ointment or, if unavailable, clean petroleum jelly (e.g., Vaseline, Aquaphor) from a new tube. Do not use over-the-counter antibiotic ointments such as Neosporin, as they may delay healing.

Do not let the wound dry out. **Do not let the wound air out.** **Do not let a scab form.**

Keep the wound covered with a simple bandage & ointment, changing it daily.

- **Sutures**: Your sutures are dissolvable and do not require removal. This is for your convenience; however, if you would like to have your wound checked for any reason, we are happy to do so. If the sutures have not dissolved after your recovery time (based on surgical location, see below) and the wound appears to be healed over, it is okay to gently brush the remaining sutures off.

- **Color:** Wounds, especially grafts and flaps, may go through a wide variety of skin color changes including a deep red, black, and yellow. This is normal and does not indicate the graft or flap was unsuccessful. Please avoid allowing the wound to dry out by keeping Vaseline or antibiotic ointment on it, as this will kill the graft or flap.

Medication Management

- **Antibiotics** Take your prescribed antibiotics as directed and complete the entire course. Take with a full glass of water and food.

- **Pain Management**: Expect some discomfort and pain, especially during the first 48-72 hours. Take pain medication regularly during this period, rather than waiting for the pain to intensify.

Acetaminophen (Tylenol) 1000 mg, four times a day, is recommended for the first 48 hours.

Adding NSAIDs (Advil, Motrin, Aleve, Aspirin) for pain will increase bleeding risk.

If you have liver issues or are a heavy drinker, the maximum dose of acetaminophen should be reduced to 2000 mg daily. Take all NSAIDs that are recommended by your other medical providers as usual but avoid adding any for pain. If you experience significant pain or if pain worsens after 72 hours, please contact our office as this may indicate an infection or other complication.

Physical Activity and Lifestyle Adjustments

Recovery Times By Surgical Location

7 days for face, neck, genitals
14 days for trunk, arms, hands, scalp, buttocks
21 days for legs, feet

- **Activity Restrictions**: **Avoid bending, straining, lifting more than 10 pounds, intercourse, or any activity that raises your heart rate during the recovery period.** Light household activities may be resumed after a few days, but be cautious with movements that could strain the surgical area.

- **Returning to Work**: Most patients require 5-7 days off work, depending on the physical demands of their job. Physically intensive work may require light duty for the duration of the recovery period.

- **Exercise**: You may resume exercise after your recovery period. Start gradually and be aware that swelling may temporarily worsen with physical activity.

- **Tobacco & Alcohol:** Avoid tobacco products since they delay healing, increase scarring, and lead to death of skin grafts or flaps. Nicotine should also be avoided; however, if you have uncontrollable cravings, nicotine in the form of non-tobacco nicotine products such as vaping or patches is preferred over tobacco. Because alcohol thins the blood, avoid alcohol. Patients dependent on alcohol should attempt limiting their alcohol intake as best as they can.

- **Travel**: Automobile travel can resume immediately. Air travel should be avoided for at least one week and preferably for up to two months for optimal cosmesis, due to the risk of increased swelling from pressure changes. Do not drive if you are taking narcotic pain medications.

Long-Term Care and Scar Management

- **Silicone Gel or Tape**: Use silicone gel or tape once the wound has healed to minimize scarring. Continue using sunscreen and petroleum jelly to protect the area and promote healing. Surgical scars can have a bad appearance the first 3 months as the scar remodels; scars continue to remodel for about a year.

- **Altered sensation**: Occasionally, you may experience itching, numbness, or tingling, if the small nerves in your skin went through the area that was cut out. These nerves grow back very slowly; it may take several months to a couple of years.

BEFORE MOHS SKIN CANCER SURGERY CARE INSTRUCTIONS

6807 Knightdale Blvd Suite C
Knightdale, NC 27545
(919) - 217- 5510

2613 N Hospital Rd
Goldsboro, NC 27534
(919) - 736 - 0222

Thank you for choosing our practice for your Mohs micrographic surgery. Your Mohs surgeon, Dr. William Farmer, is dedicated to providing you with the highest standard of care. Please review these instructions carefully to ensure a smooth and successful procedure. Should you have any questions, do not hesitate to contact our office. **Plan to be present for the Mohs surgery for 2-4 hours.**

Driving: For surgeries around the eyes, it is necessary that you arrange for someone to drive you home, as swelling may impair your vision. For other surgeries, a driver is optional but recommended.

We strongly believe that each patient should be treated like a family member in every aspect of their care. We have three goals for surgery: (1) Completely remove all the skin cancer at the site. (2) Provide you with the best possible scar for the skin cancer you had. (3) Keep you as comfortable as possible.

Mohs Micrographic Surgery

Mohs surgery is the most effective treatment for common forms of skin cancer, including basal cell carcinoma and squamous cell carcinoma. It boasts an impressive cure rate of 96-99%, even for cases where other treatments have failed. The procedure is named after Dr. Frederick Mohs, who developed the technique in the 1940's. Your Mohs surgery team will include your Mohs surgeon, a medical assistant, and a histotechnologist who processes the tissue and documents the procedure. Mohs surgery is performed under local anesthesia in our outpatient. Here is what your day may entail.

1. ***Arrival*:** You'll be escorted to the surgery room with your desired family member(s) if present, where your medical history will be reviewed, and photographs will be taken. This will be your room from start to finish. The Mohs procedure will be discussed with you, answering any questions and obtaining your consent.
2. ***Preparation*:** After family members have exited to the waiting room, you will be positioned, draped, and made comfortable. The area will be cleaned with an antiseptic, and a local numbing agent (lidocaine) will be carefully injected to deaden the area. This may cause a brief stinging or burning sensation.
3. ***Surgical Removal*:** The surgeon removes the skin tissue at the site of the skin cancer. Bleeding is controlled with cautery. A temporary dressing is applied while the tissue is processed, during which time the patient relaxes in the surgical room.
4. ***Tissue Processing and Margin Evaluation:*** The skin tissue is immediately turned into a microscope slide in the in-office lab while the patient waits, which usually takes about an hour. The slide is then examined under the microscope by the Mohs surgeon to ensure all the cancer has been removed from the skin. If cancer cells are seen, the physician will map out exactly where the cancer is and will go back and take out only that exact area. The surgeon will repeat this process until there is no skin cancer seen under the microscope.
5. ***Wound Repair*:** Once all cancer is removed, the surgeon repairs the wound, aiming to minimize scarring and preserve the natural appearance of the skin. The method of repair depends on the size, shape, and location of the wound and may involve stitches, a skin graft, or allowing the wound to heal naturally.

Pre-Surgery Checklist

- **Bandages**: We recommend paper tape, non-stick pads (e.g., Telfa), and latex-free Coban wrap.
- **Acetaminophen** (e.g., Extra Strength Tylenol): Do **not** use NSAIDs (e.g., ibuprofen, naproxen, aspirin) for pain as they can increase bleeding.
- **Ice Packs**: Prepare small, lightweight packs using crushed ice or frozen peas to be wrapped in a towel for use after surgery.
- **Snacks & Entertainment**: Surgery may take 2-4 hours, so bring food and activities to keep yourself comfortable during the wait.

- **Petroleum Jelly Ointment** (e.g., Vaseline, Aquaphor): To apply after completing prescribed antibiotics, aiding in the healing process. Use a new container to prevent contamination of the wound.
- **Hydrogen Peroxide**: For cleaning dried blood on surrounding skin or clothing, but not for use on the wound itself.
- **Silicone Scar Gel or Tape**: To minimize scarring after the wound has healed.
- **Soft Foods**: For surgeries on the head or neck, choose foods that require minimal chewing.
- **Nicotine Alternatives**: For tobacco users to avoid complications during healing.
- **Straws**: Recommended if surgery is near the mouth.
- **Eye Drops**: Only necessary if surgery is on or near the eyelids.

Days Leading Up to Surgery

- **Medication**: Continue all medications prescribed or directed by your physician, including blood thinners and aspirin. Avoid taking NSAIDS (e.g., ibuprofen, naproxen, aspirin) that are not directed by a physician more than two weeks before surgery as these will further thin your blood.
- **Diet**: Focus on a diet rich in protein and low in junk food. Green vegetables, fruits, and pineapples are recommended to help reduce bruising and swelling. Avoid vitamins and herbal supplements that thin the blood, unless prescribed for a specific condition.
- **Discontinue alcohol and tobacco**. Alcohol thins the blood and tobacco prevents wounds from healing. If you are dependent, please limit as much as you are safely able. Do this for a week prior and don't restart until after you are completely recovered.

Night Before Surgery

- **Mindset**: Approach your surgery with a positive attitude.
- **Diet**: Eat normally and take your medications as usual. This surgery does not require fasting.
- **Home Preparation**: Arrange a comfortable recovery area with pillows, blankets, books, and entertainment.
- **Hygiene**: Shower with a gentle cleanser, avoiding lotions, perfumes, hair products, and other topical products. Do not shave the surgical site, but trimming hair is acceptable, but not necessary.

Morning of Surgery

- **Mindset**: Stay positive. Focus on the fact that you will soon be rid of the burden of this cancer.
- **Diet**: Eat a full meal and take your medications as usual. Delay medications that cause frequent urination until after the procedure if preferred.
- **Clothing**: Wear loose, comfortable clothing. Be prepared for the possibility of bloodstains. Avoid wearing makeup, jewelry, or any cosmetic products.
- **Medications**: Do not take any additional pain medications, alcohol, or anxiety medications before your procedure without informing your physician.

Pre-Surgery Relaxation Techniques

1. **Prayer:** Cancer impacts the body, mind, and spirit. In order for you to heal properly, it is pertinent that you focus on more than just your body. Take time to pray before, during, and after your surgery.
2. **Deep Breathing Exercises:** Take slow, deep breaths in through your nose, allowing your abdomen to rise as you fill your lungs with air. Hold for a moment, then slowly exhale through your mouth. Repeat this for 5-10 minutes, focusing on the sensation of your breath to center your thoughts and reduce anxiety.
3. **Progressive Muscle Relaxation:** Starting from your toes and working your way up, tense each muscle group in your body for a few seconds, then slowly release. This exercise helps to relieve physical tension and calm your mind.
4. **Guided Imagery:** Close your eyes and imagine yourself in a peaceful, safe place, such as a beach, forest, or your favorite room. Engage your senses by picturing the colors, smells, and sounds around you. Spend a few minutes immersed in this imagery to reduce stress.
5. **Mindfulness Meditation:** Focus on the present moment by observing your thoughts and sensations without judgment. This can help you stay grounded and avoid becoming overwhelmed by worries about the surgery.

WHEN TO CALL THE OFFICE OR VISIT THE HOSPITAL

After-Hours Urgent Situations: Rarely surgical urgencies can occur after you have left the office. Please call our office and request to speak to Dr. Farmer or Dr. Farmer's team for urgent concerns during or after hours. While we are happy to assist, we kindly ask that you reserve the after-hours line for urgencies. Many common questions are addressed in this document.

1. **Bleeding:** If the surgical site continues to bleed after following these steps or you are unable to carry out these recommendations, please contact us immediately or visit the nearest emergency room.

   Remain Calm: Seeing blood can be alarming, but staying calm is essential to prevent an increase in heart rate and blood pressure, which can worsen bleeding.

   Initial Bleeding: Some oozing is normal. If the bandage becomes soaked with blood, remove it and apply direct pressure to the bleeding area for 30 minutes without peeking. You can use a Coban wrap or similar wrap to hold the pressure. If bleeding persists or if a blood vessel appears to be squirting, seek immediate medical attention.

   Fainting: If you or your caretaker feels faint at the sight of blood, lie down and elevate your legs until the feeling passes.

2. **Infection**: A certain degree of redness and the presence of minimal pus is normal during healing. However, spreading redness, increasing swelling, pain that worsens beyond 72 hours, increased drainage of pus, a fever over 101°F, or a foul odor from the wound are concerning signs of infection. Most infections are minimal and can be addressed during regular office hours, but please do not hesitate to contact us anytime with your concerns.

3. **Allergic Reactions**: If you experience a significant allergic reaction to medication, discontinue use and contact our office immediately.

4. **Other Serious Symptoms**: If you experience shortness of breath, chest pain, lightheadedness that does not resolve with lying down, severe vomiting, uncontrollable pain, or asymmetric swelling in your limbs, seek immediate medical attention.

Forefront Offices: **Knightdale (919) 217-5510** **Goldsboro (919) 736-0222**

WakeMed Raleigh: 3000 New Bern Ave, Raleigh, NC 27610
WakeMed North: 10000 Falls of Neuse Rd, Raleigh, NC 27614
WakeMed Cary: 1900 Kildaire Farm Rd, Cary, NC 27518
WakeMed Apex: 120 Healthplex Way, Apex, NC 27502
WakeMed Garner: 400 US-70 East, Garner, NC 27529
Duke Raleigh: 3400 Wake Forest Rd, Raleigh, NC 27609
UNC REX: 4420 Lake Boone Trail, Raleigh, NC 27607

UNC Health Wayne Goldsboro: 2700 Wayne Memorial Dr, Goldsboro, NC 27534

Prayers For Strength And Healing

Cancer impacts the body, mind, and spirit. In order for you to heal properly, it is pertinent that you focus on more than just your body. Allow these prayers to guide you through your healing process.

Morning Prayer

O Lord, as the dawn of this new day breaks, I turn to You for strength and guidance. I do not know what today will bring, but I trust in Your wisdom and love. If I am called to stand, grant me the courage to stand tall and firm. If I am to remain still, fill me with patience and calm. Should I need to lie low, help me to do so with grace. And if I am to simply rest, may I do so with dignity and peace. Let these words resonate deeply within me, and fill me with the spirit of Your enduring love. Amen.

Night Prayer

As the day draws to a close, O Lord, be our refuge and strength. Support us through the lengthening shadows and the stillness of evening, as the world around us quiets and the busyness of life subsides. When the fever of life is spent, and our tasks are done, grant us, in Your mercy, a safe haven, a holy rest, and peace at last. May Your love surround us as we sleep, and may we wake refreshed in Your care. Amen.

Before Surgery

Almighty God, as I approach this moment of surgery, I ask for Your strength and grace. Steady my heart, calm my fears, and prepare me for what lies ahead. Bless the hands of the surgeons, assistants, and all who will care for me. May their skills be a channel of Your healing power. Restore me, O Lord, to health and usefulness in Your world, and grant me a heart full of gratitude for the gift of life. In Your mercy, I pray. Amen.

After Surgery

O Lord, whose compassions never fail and whose mercies are renewed each morning, I give You thanks for the relief from the burden of this terrible cancer. Please allow me relief from pain during my recover and for the hope of health restored. Continue, I pray, the good work You have begun in me. As I regain strength day by day, may I rejoice in Your goodness and live a life that reflects Your love. Help me to always think and do those things that please You, and may Your mercy guide me now and always. Amen.

For Doctors and Assistants

O Lord, sanctify those whom You have called to the study and practice of healing. Bless the hands and hearts of the doctors and assistants who care for the sick and suffering. Strengthen them with Your life-giving Spirit, that through their ministries, the health of our community may be restored, and Your creation glorified. Grant them wisdom, patience, and compassion as they serve others. Amen.

Prayers by Specific Tradition

Christian

Prayer of St. Francis

Lord, make me an instrument of Your peace. Where there is hatred, let me sow love; where there is injury, pardon; where there is doubt, faith; where there is despair, hope; where there is darkness, light; and where there is sadness, joy. Grant that I may seek not so much to be consoled as to console; to be understood as to understand; to be loved as to love. For it is in giving that we receive; it is in pardoning that we are pardoned; and it is in dying that we are born to eternal life. Amen.

Recommended multiday prayers: Healing Novena For The Intercession Of St. John Paul II and Novena to St. Roch

"Heal me, O Lord, and I will be healed; save me and I will be saved, for you are the one I praise." - Jeremiah 17:14

"He said to her, “Daughter, your faith has healed you. Go in peace and be freed from your suffering.” - Mark 5:34

Jewish
Psalm 23
The Lord is my shepherd; I shall not want. He makes me lie down in green pastures; He leads me beside still waters; He restores my soul. He leads me in paths of righteousness for His name's sake. Even though I walk through the valley of the shadow of death, I will fear no evil, for You are with me; Your rod and Your staff, they comfort me. You prepare a table before me in the presence of my enemies; You anoint my head with oil; my cup overflows. Surely goodness and mercy shall follow me all the days of my life, and I shall dwell in the house of the Lord forever. Amen.

"The Lord bless you and keep you; The Lord make His face shine upon you, and be gracious to you; The Lord lift up His countenance upon you, and give you peace." Numbers 6:24-26

Buddhist
May all beings cross from the shores of suffering to the shores of liberation. May we move from forgetfulness to mindfulness, from ignorance to enlightenment. May we reach the state of Nirvana, where suffering ceases, and peace prevails. Sadhu! Sadhu! Sadhu! (Amen)

Hindu
O Lord, in the darkness that surrounds us, rise like the sun and dispel it with Your Divine Light. May all beings be free from danger, and may everyone realize what is good. May our thoughts be noble, and may we rejoice in the joy of all. May all beings be happy and free from disease. Lead us from the unreal to the Real, from darkness to Light, from death to Immortality. Om Shanti, Shanti, Shanti. Peace, peace, peace be unto all!

Islam
Almighty God, Lord of humankind, remove the hardship from Your servants and grant them relief from their ailments. You are the ultimate Healer; there is no cure except through Your healing. Strengthen our faith and grant us hearts that are healthy and tongues that speak truth. Set right our affairs and forgive us our sins, our errors, and our shortcomings. Ameen.

"And when I am ill, it is He who cures me." (Qur'an 26:80)

Secular/Humanist
In every part of our being, we are connected to the world around us. With each breath, we share in the collective experience of life. May we always feel our connection to those who suffer, and may they find strength in the support of others. We trust in the compassion of those around us and the science that guides the hands of our caregivers. We also trust in the narrative of our lives, knowing that our story is woven into the greater tapestry of existence. Life is a journey, one we do not walk alone. May those who are suffering feel the presence of their loved ones, now and always, through every challenge and every triumph. May it be so, in light and in love.