FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

# 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**

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**Relationship to Patient**

*Effective: 3/1/2026*