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**

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Relationship to Patient