

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 _____	<input type="checkbox"/> Mobile (cell) <input type="checkbox"/> Work <input type="checkbox"/> Home
Preferred Number _____	<input type="checkbox"/> Mobile (cell) <input type="checkbox"/> Work <input type="checkbox"/> 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:	
<input type="checkbox"/>	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.
<input type="checkbox"/>	Other _____
_____	_____
Employee Name	Date