



PATIENT INFORMATION

Date of Birth SSN# Occupation
 Last Name MI First Name
 Address
 Zip Code City State
 Referred By Sex Email
 Home# Cell# Work#
 Pharmacy name and Location

EMERGENCY CONTACT

Marital Status:
 Spouses Name Contact #
 Friends Name Contact #

INSURANCE INFORMATION

Primary Insurance Member Id
 Group # Policy#
 Secondary Insurance Member Id
 Group# Policy#

If you are not the primary subscriber - Please indicate the policy holders info below

Primary Subscriber Name
 SSN# Date of Birth

PRIMARY CARE PHYSICIAN

Phone #

Primary Care Address

HOW DID YOU HEAR ABOUT US?

Other:

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature:

Today's Date: ___ / ___ / ___

Relationship to patient (if signed by personal representative of patient): _____

Natura Dermatology and Cosmetics

1120 Bayview Drive
 Fort Lauderdale, FL 33304
 T. 954.537.4106 F.954.537.4186

SO THAT WE MAY FACILITATE PROCESSING OF ANY INSURANCE CLAIM FOR YOU

AND PAYMENT CREDIT AGREEMENT

1. I HEREBY ASSIGN TO YOU, MY HEALTH CARE PROVIDER, ALL MEDICAL AND SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH INSURANCE.
2. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION TO SECURE PAYMENT.
3. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE, AND THAT PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.
4. I UNDERSTAND AND AGREE THAT IN THE EVENT THAT I FAIL TO MAKE PAYMENT FOR SERVICES RENDERED TO ME, MY NAME AND ACCOUNT MAY BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY AND AGREE TO PAY SAID AGENCY'S FEES FOR COLLECTION, COURT COSTS, AND/OR REASONABLE ATTORNEY'S FEES THAT MAY BE INCURRED IN THE COLLECTION OF ANY OUTSTANDING BALANCE.
5. THIS OFFICE RESERVES THE RIGHT TO CHARGE INTEREST ON ANY UNPAID BALANCES AT THE RATE OF 1.5% PER MONTH.
6. I UNDERSTAND AND AGREE THAT ALL PURCHASES ARE FINAL AND THAT REFUNDS ON PRODUCTS AND/OR SERVICES PURCHASED WHETHER MEDICAL OR COSMETIC IN NATURE WILL NOT BE PROVIDED.
7. I UNDERSTAND THAT ANY AND ALL APPOINTMENTS ARE VALUABLE TIME RESERVED EXCLUSIVELY FOR ME AND IN THE EVENT THAT I CANNOT BE PRESENT AT AN APPOINTMENT, I WILL GIVE NOT LESS THAN 24 HOURS NOTICE TO THIS OFFICE TO CANCEL OR RESCHEDULE. FAILURE TO GIVE NOTICE WILL RESULT IN A \$50 NO SHOW FEE FOR REGULAR APPOINTMENTS AND A \$150 NO SHOW FEE FOR SURGICAL OR COSMETIC APPOINTMENTS, OF WHICH I AM RESPONSIBLE FOR PAYING.

POLICY REGARDING ANY SERVICES DEEMED COSMETIC BY THE PHYSICIAN IN THIS OFFICE IS AS FOLLOWS:

I FULLY UNDERSTAND AND AGREE THAT WILL RICHARDSON, MD PA WILL NOT FILE FOR COSMETIC AND/OR ELECTIVE PROCEDURES THROUGH ANY INSURANCE POLICY INCLUDING MEDICARE. THE PATIENT IS SOLELY RESPONSIBLE FOR THESE CHARGES AND WAIVES THE RIGHT TO BILL FOR ANY COSMETIC PROCEDURES AS SET FORTH HEREIN.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT, BY SIGNING BELOW I AGREE TO THE TERMS AND CONDITIONS OF THE ABOVE AGREEMENT.

SIGNED _____ TODAY'S DATE ____/____/____

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F.954.537.4186

Natura Dermatology and Cosmetics
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Privacy Officer who is the Office Manager

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F.954.537.4186

We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F.954.537.4186

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F.954.537.4186

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2.YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F.954.537.4186

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical records

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3.COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Office Manager at (954)537-4106 for further information about the complaint process.

This notice was published and becomes effective on **1/1/2010**.

SO THAT WE MAY FACILITATE PROCESSING OF ANY INSURANCE CLAIM FOR YOU

AND PAYMENT CREDIT AGREEMENT

1. I HEREBY ASSIGN TO YOU, MY HEALTH CARE PROVIDER, ALL MEDICAL AND SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH INSURANCE.
2. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION TO SECURE PAYMENT.
3. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE, AND THAT PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.
4. I UNDERSTAND AND AGREE THAT IN THE EVENT THAT I FAIL TO MAKE PAYMENT FOR SERVICES RENDERED TO ME, MY NAME AND ACCOUNT MAY BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY AND AGREE TO PAY SAID AGENCY'S FEES FOR COLLECTION, COURT COSTS, AND/OR REASONABLE ATTORNEY'S FEES THAT MAY BE INCURRED IN THE COLLECTION OF ANY OUTSTANDING BALANCE.
5. THIS OFFICE RESERVES THE RIGHT TO CHARGE INTEREST ON ANY UNPAID BALANCES AT THE RATE OF 1.5% PER MONTH.
6. I UNDERSTAND AND AGREE THAT ALL PURCHASES ARE FINAL AND THAT REFUNDS ON PRODUCTS AND/OR SERVICES PURCHASED WHETHER MEDICAL OR COSMETIC IN NATURE WILL NOT BE PROVIDED.
7. I UNDERSTAND THAT ANY AND ALL APPOINTMENTS ARE VALUABLE TIME RESERVED EXCLUSIVELY FOR ME AND IN THE EVENT THAT I CANNOT BE PRESENT AT AN APPOINTMENT, I WILL GIVE NOT LESS THAN 24 HOURS NOTICE TO THIS OFFICE TO CANCEL OR RESCHEDULE. FAILURE TO GIVE NOTICE WILL RESULT IN A \$50 NO SHOW FEE FOR REGULAR APPOINTMENTS AND A \$150 NO SHOW FEE FOR SURGICAL OR COSMETIC APPOINTMENTS, OF WHICH I AM RESPONSIBLE FOR PAYING.

POLICY REGARDING ANY SERVICES DEEMED COSMETIC BY THE PHYSICIAN IN THIS OFFICE IS AS FOLLOWS:

I FULLY UNDERSTAND AND AGREE THAT WILL RICHARDSON, MD PA WILL NOT FILE FOR COSMETIC AND/OR ELECTIVE PROCEDURES THROUGH ANY INSURANCE POLICY INCLUDING MEDICARE. THE PATIENT IS SOLEY RESPONSIBLE FOR THESE CHARGES AND WAIVES THE RIGHT TO BILL FOR ANY COSMETIC PROCEDURES AS SET FORTH HEREIN.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT, BY SIGNING BELOW I AGREE TO THE TERMS AND CONDITIONS OF THE ABOVE AGREEMENT.

SIGNED _____ TODAY'S DATE ___/___/_____

Natura Dermatology and Cosmetics

1120 Bayview Drive
Fort Lauderdale, FL 33304
T. 954.537.4106 F. 954.537.4186



CELEBRATING 15 YEARS

CONSENT FOR SENSITIVE EXAM

"I give permission to Will Richardson MD PA and affiliates to perform a thorough skin exam including examination of the pelvic region. This will include examining the external genitalia (penis, vagina, scrotum, labia, etc.) visually. To conduct a thorough exam, I understand that the provider may have to touch my genitals to evaluate for presence of hidden lesions by folds of skin."

- I request a thorough exam and **agree** to the above.
- I **decline** a pelvic exam.

Please indicate your preference for a chaperone by checking the box below:

- I prefer a chaperone for my exam.
- I do not prefer a chaperone for my exam and release and hold harmless Will Richardson MD PA from any future claims.

PRINT NAME

Signature

Date



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____