NATURA
DERMATOLOGY & COSMETICS

PATIENT INFORMATION

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

EMERGENCY CONTACT

Marital Status:	Single Married Partnered Widowed		
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?	Google Bing/Yahoo Facebook Twitter Yelp 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

6552 North State Road 7
Coconut Creek, FL 33073
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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 RESONABLE 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____/____/_____

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