



WILL RICHARDSON, MD PA  
BOARD CERTIFIED DERMATOLOGIST  
1120 BAYVIEW DRIVE – FORT LAUDERDALE  
PHONE: 954.537.4106 FAX: 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 INTITLED 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 REDERED 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. FAILURE TO GIVE NOTICE WILL RESULT IN A \$150 NO SHOW FEE I AM RESPONSIBLE FOR PAYING.

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 \_\_\_\_/\_\_\_\_/\_\_\_\_