PATIENT NAME: _____
(Printed)

DATE OF BIRTH: _____

AUTHORIZATION FOR TREATMENT: I authorize such examinations, treatments, and minor dermatological or cosmetic procedures as may be prescribed the Sona Dermatology & Med Spa (the "Practice") provider in charge of my care. I understand that I have the right to be informed by my provider(s) of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am directly responsible for all charges for services and items rendered by the Practice regardless of insurance coverage or whether such services and items are needed as a result of an accident in which another person is at fault. I understand that I am responsible for any deductibles, co-pays, co-insurance amounts. In the event a service is not covered by insurance for any reason, in whole or in part, I agree to pay for all outstanding charges for the services and items rendered during my visit. If I fail to pay all charges and the Practice use a collection agency to collect unpaid charges, I agree to pay the reasonable cost of collection agency fees in addition to the unpaid charges. I consent and authorize the Practice and its agents to contact outside data sources of its choosing, including credit reporting agencies, for purposes related to my account, including evaluating and assessing my credit worthiness and the viability of collecting any amounts due for services and items I receive, whether at this time or on subsequent visits.

ASSIGNMENT OF INSURANCE BENEFITS (if applicable): I hereby authorize payment by my insurance carrier directly to the Practice for any services or items provided to me by the Practice. I assign all my rights to the Practice under any applicable policy of insurance. I further warrant and represent that any insurance which I assign is valid insurance and in effect and that I have the right to make this assignment.

ACKNOWLEDGEMENT OF PROVISION OF NOTICE OF PRIVACY PRACTICES: I understand that the Practice will use and disclose my personal health information in accordance with the Notice of Privacy Practices (the "NPP"). I acknowledge that I have been provided access to the NPP and consent to uses and disclosures of my health information as outlined in the NPP.

COMMUNICATION FROM THE PRACTICE: I hereby consent and authorize the Practice including its employees and agents to contact me by mail, email, fax, telephone call, and text message including a wireless number to communicate with me regarding my appointments with or services and items received from the Practice, my account, or for marketing purposes. I understand and consent to the use of pre-recorded and/or an automatic dialing service in connection with any communication made to me by the Practice. I further understand that e-mail and text message are unsecured forms of communication and therefore, that there is some risk that my personal health information may be disclosed to or intercepted by an unauthorized third party. I understand that I can withdraw my consent to e-mail and text message communication at any time.

DESIGNATION OF PERSONAL REPRESENTATIVE: I hereby designate the following individual(s) as my personal representative(s) and authorize the Practice to release any verbal or written information about me to my personal representatives as may be needed to assist with my ongoing treatment. This designation and authorization will remain in effect until revoked by me in writing.

_____ _____
Signature (Patient or Authorized Representative) Date

Personal Representative Name(s)	**Relationship**	**Phone Number**

_____ _____
Signature (Patient or Authorized Representative) Date