



OFFICE POLICIES

Thank you for choosing Spencer Dermatology and Skin Surgery Center for your health care needs. We recognize that you have a choice in health care providers and we appreciate the trust that you have placed in us. The following details our office policies and allows us to provide excellent health care to all of our patients in an office atmosphere based on mutual respect. Please review and initial next to each office policy summary acknowledging that you have read and understand the policy.

____ Your first visit, or any visit in which you will provide our office with an insurance update, will (initial) require you to arrive 10 minutes prior to your appointment time in order to complete the new patient registration process or update your insurance information. We will obtain a photocopy of your current insurance card and picture identification.

____ Your co-payment, coinsurance and / or deductible will be collected on the day of your visit. Our EMR (initial) system is linked to the major insurance carriers, so we are able to determine these amounts on the day of your visit. Any outstanding balance on your account will be collected as well. Our office accepts cash, checks, American Express, Discover, MasterCard and Visa. We request the right to make an imprint of your valid credit card to keep on file. In the event that your account goes delinquent we reserve the legal right to deduct payment.

____ It is our office policy to file your claim with your primary insurance carrier, or if you are a Medicare (initial) patient, we will file Medicare and a secondary insurance claim. We will appeal all denied claims until efforts are exhausted. If the claim is denied, responsibility will be placed with you, the patient.

____ We respect your time. We try our very best to stay on schedule, but occasionally a patient requires (initial) more than the allotted amount of time due to urgent or complicated problem. Thank you for understanding that we will provide this same level of attention to you in the event that you have a complicated problem.

____ We have a same day appointment policy. In the event that you have an urgent health care problem (initial) that requires immediate attention, we will see you in the office that day. In order to accommodate patients in this manner our office requires 24 hour notice for cancellations. We realize that in rare cases you will be unable to provide the required 24 hour notice. Appointments not cancelled with 24 hours of the notice will be coded as no – shows and charged \$25.00. If you need to cancel an appointment after our office is closed, please leave a message with our answering service.

____ If you are going to be more than 30 minutes late for a scheduled appointment, it may be necessary to (initial) reschedule your appointment. We will make every effort to see you on the day of your appointment. If, however, the wait time will exceed your availability, we will be happy to reschedule the appointment for you.

____ Our office hours are Monday thru Thursday from 9:00am to 5:00pm and Friday from 9:00 am to 6:00 (initial) pm. We provide after hours and weekend call coverage in the event of **EMERGENCIES ONLY**. Pages that are not urgent nature **WILL NOT** be returned. Our answering service will take the necessary information and call the Practitioner on Call.

____ Routine prescription refills will be given during our office hours. Please call your pharmacy to have a (initial) request faxed to our office. Please allow 48 hours (not including weekends) for your request to be refilled.

____ Please note that **NO controlled substance** requests can be filled via phone as per DEA regulations. (initial)

____ **NOTICE: WE ACCEPT ONLY CASH OR CREDIT CARD FOR COSMETIC TREATMENTS AND PRODUCT SOLD IN THE OFFICE.** (initial)

____ I understand that my visit today may be with a certified Physician Assistant who works closely with (initial) and is supervised by Dr. James Spencer. If for any reason I feel that I should be directly consulted by the Physician during my visit, or if the PA recommends that Dr. Spencer should become involved in my case, there will be an opportunity for such consultation.

We look forward to the opportunity to work with you to meet your health care needs.

I have read, understand and agree to abide by the office policies described above.

Print Name

Signature

Date