



## 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 require you to arrive (initial) 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 system is linked to (initial) 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, Visa, MasterCard, American Express and Discover as well as Bank Debit cards.

\_\_\_\_ It is our office policy to file your claim with your primary insurance carrier. If you are a Medicare patient, we will file with (initial) Medicare and a secondary insurance. 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 more than the allotted (initial) 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 should have the same need.

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

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

\_\_\_\_ Our office hours are Monday thru Friday from 9:00am to 5:00pm. We provide after hours and weekend call coverage in the (initial) 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 request faxed to our (initial) office and 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 PAYMENTS FOR COSMETIC TREATMENTS AND (initial) PRODUCT SOLD IN THE OFFICE.**

\_\_\_\_ I understand that I may be scheduled with a certified Physician Assistant who works closely with and is supervised by (initial) 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.

*Welcome to Spencer Dermatology. 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



**Medicare Patient Registration**

**Name:**

\_\_\_\_\_  Jr.  Sr.  
First Middle Last

Prefer to be called: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  F  M Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Address: \_\_\_\_\_  
Street # Street Name Apt #

\_\_\_\_\_ City State Zip

Email Address: \_\_\_\_\_ \*(to communicate practice information/events only)

Day Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Evening Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Drivers License Number: \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

**May we leave personal medical information on your Voicemail at home?**  Yes  No

**May we e-mail personal medical information to you?**  Yes  No

**Do you give our office permission to discuss your medical information with family members?**

Yes  No If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_)\_\_\_\_ Phone # (evening): (\_\_\_\_)\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_)\_\_\_\_ Phone # (evening): (\_\_\_\_)\_\_\_\_

**Emergency Contact Information:**

In case of Emergency, whom should we notify? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_





**Spencer Dermatology  
& SKIN SURGERY CENTER**

**Patient Medication List**

Please fill out as completely as possible.

**NAME** \_\_\_\_\_

**ALLERGIES TO MEDICATIONS** (please include reaction) \_\_\_\_\_  
\_\_\_\_\_

**ALL CURRENT MEDICATION** (Please list)

Are you currently taking: \_\_\_ Aspirin \_\_\_ Coumadin \_\_\_ Plavix

- |           |           |
|-----------|-----------|
| 1. _____  | 2. _____  |
| 3. _____  | 4. _____  |
| 5. _____  | 6. _____  |
| 7. _____  | 8. _____  |
| 9. _____  | 10. _____ |
| 11. _____ | 12. _____ |
| 13. _____ | 14. _____ |
| 15. _____ | 16. _____ |
| 17. _____ | 18. _____ |
| 19. _____ | 20. _____ |

Are you allergic to: **Lidocaine**? Y\_\_ N\_\_ or **Latex**? Y\_\_ N\_\_

Do you take antibiotics before dental work? Y\_\_ N\_\_

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## Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: \_\_\_\_\_  
Printed Name – Patient or Representative

\_\_\_\_\_  
Signature

Relationship to Patient (if other than patient): \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_

\_\_\_\_\_ FOR OFFICE USE ONLY \_\_\_\_\_

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- The patient refused to sign despite good faith efforts
- The patient was unaccompanied and not alert and oriented
- The patient was unaccompanied and needed emergency care
- Other, (explain): \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Employee Title: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_