SPENCER DERMATOLOGY

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New Patient Registration

Today's Date: ____/____/____

Name: _____
(First) (Middle) (Last) (Suffix)

Date of Birth: ____/____/____ Sex: ☐F ☐M Marital Status: ☐Single ☐Married ☐Other

Address: _____

_____
(City) (State) (Zip)

(____) ____-____ (____) ____-____ _____
(Home phone) (Cell phone) (E-mail address) By providing this, I authorize this office to contact me via email.

These questions are included to comply with Federal Health Guidelines – We are required to ask this information

Ethnicity (check one) ☐Hispanic or Latino ☐Not Hispanic or Latino ☐I choose not to specify

Race (check one) ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐White
☐ Native Hawaiian/Other Pacific Island ☐ I choose not to specify ☐ Other _____

Preferred Language (check one) ☐ English ☐ Spanish ☐ American Sign Language
☐I choose not to specify ☐Other_____

How did you hear about us? _____

Primary Care Physician: _____ Phone: (____) ____-____

DO YOU HAVE HEALTH INSURANCE? ☐YES ☐NO ***IF YES, PLEASE PROVIDE BELOW***

Primary Insurance: _____ Phone: (____) ____-____

Policy Owner: _____ Date of Birth: ____/____/____

Member ID: _____ Group #: _____

Secondary Insurance: _____ Phone: (____) ____-____

Policy Owner: _____ Date of Birth: ____/____/____

Member ID: _____ Group #: _____

Please present your insurance card(s) and your photo I.D. to the receptionist who will make a copy for your file and return them to you

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of our financial policies. *PAYMENT IS EXPECTED FROM YOU FOR "YOUR PORTION OF THE CHARGES" AT TIME OF SERVICE*. For your convenience, we accept *CASH, DEBIT, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER* and *CARE CREDIT*. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the release of necessary medical information to process your insurance claims (if any) and herein authorize payment of medical benefits to the provider when an assigned claim is filed.

_____ _____ ____/____/____
(Signature) (If signature is not from patient, please provide name ***and*** relation) (Date)

Financially Responsible Party (legal guardian, power of attorney, etc.....)

_____ _____ _____
(Relation) (Print Full Name) (Sign)

Address: _____

Phone: (____) ____-____

SPENCER DERMATOLOGY

OFFICE POLICIES

Thank you for choosing Spencer Dermatology and Skin Surgery Center for your dermatology 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.

_____ (initial) Your first visit, or any visit in which you will provide our office with an insurance update, will require you to arrive 15 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 photo I.D.

_____ (initial) We respect your time. We try our very best to stay on schedule, but occasionally a patient requires 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 should have the same need.

_____ (initial) **We have a same day appointment policy. In the event that you have an urgent health care problem 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 hours notice for cancellations. Appointments cancelled within 24 hours of the appointment will be coded "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**.

_____ (initial) If you are going to be more than 15 minutes late for a scheduled appointment, it may be necessary to reschedule. 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.

_____ (initial) Our office hours are Monday thru Friday from 8:00am to 4:00pm. We provide after hours and weekend call coverage in the event of **EMERGENCIES ONLY**. Our answering service will take the necessary information and call the Provider On-Call. Pages that are not urgent nature **WILL NOT** be returned

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

_____ (initial) Please note that **NO controlled substance** prescriptions can be filled via phone or electronically as per DEA regulations.

_____ (initial) **NOTICE: WE ACCEPT ONLY CASH, CARE CREDIT, CREDIT/DEBIT CARD PAYMENTS FOR COSMETIC TREATMENTS AND PRODUCTS SOLD IN THE OFFICE.**

_____ (initial) I understand that if scheduled with the Certified Physician Assistant, if for any reason I feel that I should be directly consulted by a Physician during my visit, or if the PAC recommends that a MD 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 dermatology needs.

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

Print Patient Name or Legal Guardian	Signature of Patient or Legal Guardian	Date

SPENCER DERMATOLOGY

Patient Medication List

Please fill out as completely as possible.

NAME _____

ALLERGIES TO MEDICATIONS (please include reaction) _____

_____

PREFERRED PHARMACY: _____ **PHONE:** _____

ADDRESS: _____

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__

_____ _____

Signature of Patient or Legal Guardian Date

REV 06/2017

SPENCER DERMATOLOGY

PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Spencer Dermatology & Skin Surgery Center will use your medical information for the following:

1. **TREATMENT:** Including providing your medical records to consulting clinicians and your insurance companies.
2. **PAYMENT:** We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical records to pay the claim.
3. **HEALTH CARE OPERATIONS:** Any others involved in your healthcare.

The entire Private Policy Notices of Spencer Dermatology & Skin Surgery Center is available at our front desk for your perusal.

In conjunction with these privacy practices, you will need to provide us with the following information. The information will be the minimum necessary based on the professional opinion of the healthcare provider.

May we leave personal medical information on your Voicemail at home? ❑ YES ❑ NO

Do you give our office permission to discuss your medical health 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: (____) _____

_____ _____

Printed Name of Patient or Legal Guardian Relationship to Patient

_____ _____

Signature Date

_____ _____

Witness Date

NOTICE TO THE VALUED PATIENTS OF ADVANCED DERMATOLOGY AND COSMETIC SURGERY

Effective March 2018, Advanced Dermatology and Cosmetic Surgery (ADCS) will charge a fee to patients who fail to cancel appointments at least 24 hours prior to the scheduled appointment.

The fees are as follows:

(1) $50.00 for scheduled surgical appointments;

(2) $25.00 for scheduled office visits and other types of scheduled appointments including Aesthetics.

ADCS regrets this charge is necessary however, we are experiencing a huge demand for appointments. Our physician's time is very valuable to patients who must be seen.

_____

Patient or Legal Guardian signature (sign after printing)

_____

Date