Spencer Wellness Centre
BIO-IDENTICAL HORMONES • PRP • AESTHETICS

69 E. Garner Rd, Ste 300, Brownsburg, IN 46112
(P) 317-852-3616 (F) 317-852-6969
7202 East 71st Street, Indianapolis, IN 46256
(P) 317-588-1000 (F) 317-588-3003
www.spencerwellness.com

Dear New Patient,

We are excited to welcome you to Spencer Wellness Centre!

As a new patient to our practice, we would like to provide you with important information. Please read all forms to ensure your experience is efficient and satisfactory.

Before Your First Visit:

1. You will receive an invitation to our patient portal. We highly recommend you complete this. Your portal will allow you to view lab results, appointment notes, and communicate with our office staff.
2. Complete your self check-in 1-2 days prior to your appointment. This will walk you through the initial entry of your medical history information and is pertinent to the intake process.
3. **Arrival time is 15 minutes prior to your scheduled appointment.** This is necessary to complete any additional paperwork and allow time for us to complete your registration prior to the start of your visit.
4. Be sure to bring your Driver's License or an alternative government issued ID, and insurance card to provide to Pathology Laboratories for any lab services rendered.
5. **Any lab results that you wish to discuss during your visit must be received by our office 2 business days prior to your appointment.** You can request your doctor to send records to us via fax: (317) 588-3003, or email: info@spencerwellness.com**.**

Appointments:

If you are going to be late, please contact our office to notify us as soon as possible. We will always do our best to accommodate you! If you are more than 15 minutes late, you may be asked to reschedule.

We understand that everyone's time is valuable and strive to offer convenient appointment times to all our patients. If you cannot keep your appointment, we require 48 hour advance notice **during our regular business hours**. Please be aware that short notice cancellation will result in a $100 missed appointment fee; your appointment down-payment would be applied to this charge.

Insurance:

Spencer Wellness Centre does NOT participate or file claims with ANY insurance plans, including Medicare and/or Medicaid. You may elect to SELF-submit claims for potential reimbursement. Any questions regarding coverage and claims filing should be directed to your insurance carrier or plan administrator. **All labs can be filed to your insurance by the testing facility, including lab services within our practice.**

We look forward to meeting you, and assisting you with aging healthier and living happier!

Respectfully,

Spencer Wellness Centre Team

Spencer Wellness Centre

PATIENT REGISTRATION INFORMATION

Name: _____ Date of Birth: _____ Soc Sec #: _____

Primary Phone: _____ Home/Work/Cell Alternate Phone: _____ Home/Work/Cell

Email: _____ Preferred contact method: _____

Address: _____ City/ST: _____ ZIP: _____

Marital Status: _____ Sex: M / F Occupation: _____

Who should we thank for referring you? _____

Emergency Contact Name: _____ Phone: _____

Parent/Guardian Responsible for account (minors): _____

TREATMENT CONSENT

I understand that Spencer Wellness Centre is not a traditional medical healthcare provider and that some conditions must be managed by my primary care physician. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as to the result of any treatment received. I agree to complete any requested lab testing or follow-up appointments deemed necessary by my provider for my continuation of care.

Name of Responsible Party: _____

Signature: _____ Date: _____

FINANCIAL CONSENT

I understand that Spencer Wellness Centre does not participate with any insurance plans and does not file claims on my behalf. I understand that I am financially responsible for all charges and for all services rendered on my behalf or my dependents. I understand that the cost of my office visits will vary, and that final determination of cost is made at the time of service. I agree to make all payments at the time of service. Any checks retruned for non-suffcient funds will be subject to a $30 processing fee. Any oustanding balances must be paid within 10 days or prior to the next appointment, whichever occurs first. SWC reserves the right of check refusal. I understand that accounts in violation of SWC finacial policy are subject to placement with a thrid-party collections agency, which may be reported to credit bureaus. I understand that should such instance occur, I will be responsible for any applicable late fees, collections fees up to 30% of the initial balance, and any attorney fees applicable to the pursuit of unpaid balances.

Name of Responsible Party: _____

Signature: _____ Date: _____

Spencer Wellness Centre

Practice Policies and Information

Please Initial Each Section

PATIENTS RIGHTS

-To be treated with respect and recognition of dignity and right to privacy. -To receive care that is considerate and respects personal values and belief system. -Personal privacy and confidentiality of information. -Reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability. -Participate in an informed way in the decision-making process regarding treatment planning. -Discuss with practitioner appropriate/medically necessary treatment options for conditions regardless of cost/benefit coverage. -Adequate and humane services regardless of the source(s) of financial support. -Request access to Protected Health Information (PHI). -Request to inspect and obtain a copy of PHI, to amend PHI or to restrict the use of PHI, and to receive an accounting of disclosures of PHI.

PATIENT RIGHTS - **PATIENT INITIALS** _____

PATIENT RESPONSIBILITIES

I agree to provide (to the extent possible) my treating practitioner with the information needed in order to receive appropriate care. I understand that it is my responsibility to understand my health problems and to participate, to the degree possible, in developing with my treating practitioner agreed upon treatment goals. I agree to treat the staff of SWC in a professional and courteous manner. I understand that it is my responsibility to follow plans and instructions for care that I have agreed upon with my treating practitioner. I understand that it is my responsibility to complete lab work and follow-up appointments necessary for my continuation of care.

PATIENT RESPONSIBILITIES - **PATIENT INITIALS** _____

CHECK IN PROCEDURE

Please check in with our receptionist when you arrive for your appointment. Please be sure to update any information that may have changed since your last visit (name, address, phone number, email, etc.) Please be prepared to pay any past balances on your account. **IF YOU ARRIVE MORE THAN 15 MINUTES LATE FOR YOUR SCHEDULED TIME, YOU MAY BE REQUIRED TO RESCHEDULE SO THAT OTHER PATIENTS ARE NOT INCONVENIENCED**

CHECK IN PROCEDURE - **PATIENT INITIALS** _____

MEDICATION REFILLS/QUESTIONS/CONCERNS

Prescription refill requests should go directly to your pharmacy; your pharmacy will contact us for authorization if needed. Most questions and concerns regarding medications should be addressed during your office visit. If questions should arise between appointments, you may call the office and leave a message on the nurse's voicemail or with staff. A team member will follow-up with you after your provider reviews your questions/concerns. The provider will not personally return your call. For extensive questions that require medical decision making, changes to prescriptions or treatment, or new prescription requests, you will be required to schedule an office visit with your provider.

MEDICATION REFILLS/QUESTIONS/CONCERNS - **PATIENT INITIALS** _____

EMERGENCIES

Spencer Wellness Centre (SWC) is a private practice and is not designed as a crisis unit or primary care. In the event that you ever feel you are in a crisis DIAL 911 or go directly to the emergency room. Our after-hours emergency line is for non-life-threatening emergencies only. This line is not for prescriptions, refill requests or questions that can be addressed on the next business day.

EMERGENCIES - **PATIENT INITIALS** _____

INSURANCE NOTICE

Spencer Wellness Centre does NOT participate or file claims with ANY insurance plans, including Medicare and/or Medicaid. You may elect to SELF-submit claims to your insurance provider for potential reimbursement. Any questions regarding coverage and claims filing or processing of claims should be directed to your insurance carrier or plan administrator. **All labs can be filed to your insurance by the testing facility, including lab services within our practice.**

INSURANCE NOTICE - **PATIENT INITIALS** _____

LAB TESTING AND RESULTS

*Please see Notification of Lab Services page.

NO SHOW/LATE CANCELED APPOINTMENTS

$100 charge will be imposed for EACH appointment missed or not canceled with at least 48 BUSINESS hours advance notice. NOTICE MUST BE RECEIVED WITHIN OUR NORMAL WORK HOURS. APPOINTMENTS CANCELED VIA VOICE MESSAGE LEFT AFTER 4:30PM ON THURSDAY FOR A MONDAY APPOINTMENT WILL STILL INCUR A CHARGE. Payment will automatically be charged to the card on file on the day of the missed appointment. Balances due to declined payment will be due within 10 days of the missed/late canceled appointment or before your next visit, whichever occurs first. Multiple missed or late canceled appointments may result in a discharge from our practice.

NO SHOW/LATE CANCELED APPOINTMENT - **PATIENT INITIALS _____**

CLAIM/CHARGE DISPUTE

Front office staff, medical assistants, and/or billing office personnel are unable to waive or modify fees. The decision rests with the administration of SWC. The patient must submit a written account dispute to address any specific concerns.

CLAIM/CHARGE DISPUTE - **PATIENT INITIALS _____**

MEDICAL RECORDS

A current release of information is required for all requests. All requests for medical records will be charged according to Indiana State Law. Payment is due prior to the processing of your request. There is no charge for records released directly to another healthcare professional SWC has referred to for treatment purposes.

MEDICAL RECORDS - **PATIENT INITIALS _____**

DOCUMENT PREPARATION

A fee of $30.00 is required for SWC to complete paperwork (including but not limited to: work, disability, life insurance, letters, FMLA forms, etc.) Payment in full is required prior to the completion and release of said paperwork.

DOCUMENT PREPARATION- **PATIENT INITIALS _____**

RELEASE OF INFORMATION

A Release of Information must be completed to allow SWC to discuss appointment scheduling, billing, treatment plants etc. with designated family members, parents, guardians, other personal parties, etc. A release is not required for parents/guardians of children under the age of 18. A release must also be completed to allow SWC to send records, obtain records, or share information with other professional individuals, etc. A separate release is required for each individual and/or organization.

RELEASE OF INFORMATION - **PATIENT INITIALS _____**

NOTICE OF PRIVACY PRACTICES

Our Privacy Practices are posted in our office. A copy can be provided upon your request.

I certify that I have read and understand all of Spencer Wellness Centre's above detailed policies. As a patient of Spencer Wellness Centre, I agree to abide by office policies to the best of my ability and understand that failure to do so could result in termination of my provider-patient relationship with the practice and its affiliates.

Patient Name_____

Signature_____ Date_____

Spencer Wellness Centre

ACKNOWLEDGEMENT AND AGREEMENT OF CANCELLATION CHARGE

I have been advised of the No-Show/Late Canceled Appointments policy as written in the signed Practice Policies and Information. I understand that it is my responsibility to maintain updated contact information to ensure that I will be properly notified of any scheduled appointments. I understand that there will be a cancellation charge of $100 for any appointments not canceled at least 48 hours or 2 business days (Monday – Thursday) prior to my scheduled appointment time. I authorize the below listed card to be automatically charged for this fee, without my consent on the date of the transaction. I understand that this agreement does not expire, and any changes required by me to the payment method on file must be submitted in writing.

_____ _____

CREDIT CARD NUMBER Expiration CVV

_____ _____

CARDHOLDER NAME BILLING ZIP CODE

_____ I decline to provide credit card information for automatic billing. I understand that choosing to do so will require me to pay my estimated balance for services at the time of scheduling. I am aware that the pre-paid amount is an estimate and final determination of cost will be made on the date of service. I agree to pay any remaining balance on the date of service.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE DATE

_____ I wish to keep the above credit card on file with Spencer Wellness Centre for all services and/or products purchased. I agree to allow SWC to charge my credit card on or after the effective date and before the expiration. I acknowledge that:

- my credit card will be charged on or after the date of service while this agreement is in effect.
- I agree to an annual maximum charge amount of $_____ for automatic transactions. If the annual amount is reached, I am aware that I will have to update this document to continue automatic payments.
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated with U.S. Bank that partners with Spencer Wellness Centre.
- I will receive receipts detailing the amount charged.
- I may cancel this agreement at any time by submitting a written request to SWC.

_____ _____

PATIENT SIGNATURE DATE

Spencer Wellness Centre

Notification of Lab Services

This notification of lab services is to provide clarification regarding lab policies and patient responsibility. You must have an order for lab testing in your chart or physically on hand for tests to be performed. If you do not have an order, you will typically need an appointment with your provider to obtain one.

Spencer Wellness Centre (SWC) offers in-office lab services as a convenience to our patients. If you so choose to have labs drawn at our facility, the testing is performed by Pathology Laboratories. Pathology Laboratories is a separate entity from Spencer Wellness Centre.

Pathology Laboratories is a traditional lab and is in-network with most insurance carriers. **It is your responsibility to provide Pathology Laboratories with your insurance information.** Pathology Laboratories will submit a claim for services to your insurance, and you will be billed the remaining amount according to insurance benefits. You will be responsible for the full EOB amount according to your insurance carrier.

SWC does not verify your benefits or check network status of our insurance with this or any lab testing services. It is the patient's responsibility to know and understand the benefit plan with their insurance carrier. If you wish to confirm the network status of your insurance policy with Pathology Laboratories, they can be contacted at (419) 291-4414.

For patients with no insurance or that wish to not bill insurance for lab testing, payment for labs will be required at time of service. Pricing will be provided at the patient's request.

You are NOT required to have labs drawn in our office. You may at any time request a lab order and have labs performed at the facility of your choosing. If you have labs performed elsewhere it is your responsibility to ensure the results are sent to your provider at SWC at least 2 business days prior to your scheduled appointment to review results.

Test results completed with Pathology Laboratories can be viewed in your patient portal upon request. Questions/concerns regarding your results are reviewed during your follow-up visit. **Interpretation of results will not be provided prior to your scheduled appointment**.

By signing below, you acknowledge receipt and understanding of this lab services notification.

Patients Name _____

Signature _____ **Date** _____

Spencer Wellness Centre

Patient Consent Form

(Patient Consent for Use and Disclosure of Protected Health Information)

I hereby give my consent to **Spencer Wellness Centre** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by **Spencer Wellness Centre** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Spencer Wellness Centre** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Spencer Wellness Centre.**

With this consent, **Spencer Wellness Centre** may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Spencer Wellness Centre** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **Spencer Wellness Centre** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Spencer Wellness Centre** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Spencer Wellness Centre** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this, or later revoke it, **Spencer Wellness Centre** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient’s Name **Date**

_____

Print Name of Patient of Legal Guardian, if applicable