

# **Patient Registration Packet**

**Kevin H. Spicer, MD**  
152 Cannon Street, Suite B  
Charleston, SC 29403  
[www.doctorspicer.com](http://www.doctorspicer.com)

**Please fill out if you are new to this practice**

Kevin H. Spicer M.D.  
*Child, Adolescent and Adult Psychiatry*

152 Cannon Street, Suite B  
Charleston, SC 29403

Tel: (843) 723-5499  
Fax: (843) 723-5497

**REGISTRATION INFORMATION**

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

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

Address: \_\_\_\_\_

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

Phone (hm): \_\_\_\_ - \_\_\_\_ - \_\_\_\_ can a message be left at this number? \_\_\_\_

Phone (wk): \_\_\_\_ - \_\_\_\_ - \_\_\_\_ can a message be left at this number? \_\_\_\_

Phone (cell): \_\_\_\_ - \_\_\_\_ - \_\_\_\_ can a message be left at this number? \_\_\_\_

How do you prefer to be contacted? \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital status: \_\_\_\_\_ Spouse (if married): \_\_\_\_\_

Educational background: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Referral Contact Information: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Gender:  Male  Female

**In case of Emergency Contact:**

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

Phone: \_\_\_\_\_

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**If Patient Is A Minor:**

	<u>Legal Guardian #1</u>	<u>Legal Guardian #2</u>
<b>Name:</b>	_____	_____
<b>Address:</b>	_____	_____
	_____	_____
<b>Phone (H):</b>	_____	_____
<b>Phone (W):</b>	_____	_____
<b>Phone (C):</b>	_____	_____
<b>Relationship</b>		
<b>To Patient:</b>	_____	_____
<b>Who currently has legal custody of this child?</b>	_____	
<b>Child's current school:</b>	_____	<b>Grade:</b> _____
<b>Ages that child:</b>	Crawled _____ Walked _____ Talked _____ Potty Trained _____	

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**Medical History Self Report**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Allergies to Food, Medicine, Other:** \_\_\_\_\_

**Current Family Physician:** \_\_\_\_\_ **Date of Last Physical Exam:** \_\_\_\_\_

**Current Pharmacy & Phone Number:** \_\_\_\_\_

**Are there currently or have there previously been problems with any of the following?**

	Yes/No		Yes/No
Skin Problems	_____	Eating	_____
Wounds not healing/easy bruising	_____	Alcohol	_____
Glaucoma/Vision Problems	_____	Street Drugs	_____ <input type="checkbox"/>
Gum(s)/Teeth	_____ <input type="checkbox"/>	High Blood Pressure	_____ <input type="checkbox"/>
Hearing	_____	Heart Disease/Chest Pain	_____ <input type="checkbox"/>
Headaches	_____ <input type="checkbox"/>	Rheumatic Fever	_____ <input type="checkbox"/>
Head Injuries	_____ <input type="checkbox"/>	Nausea/Vomiting	_____ <input type="checkbox"/>
Blackouts/Fainting	_____	Ulcers	_____ <input type="checkbox"/>
Numbness/Tingling	_____	Liver Disease or jaundice	_____ <input type="checkbox"/>
Thyroid Problems	_____	Kidney/Bladder problems	_____ <input type="checkbox"/>
Blood Sugar	_____	Pregnancy (due _____)	_____
Sickle Cell	_____	Sexual Function	_____ <input type="checkbox"/>
HIV/AIDS	_____	Difficulty Walking/Standing	_____ <input type="checkbox"/>
Fatigue	_____	Pain	_____
Anemia/Low Blood Count	_____	Sleeping too much	_____ <input type="checkbox"/>
Breathing/Shortness of Breath	_____ <input type="checkbox"/>	Sleeping too Little	_____ <input type="checkbox"/>
Fever	_____	Lead/Chemical Exposure	_____ <input type="checkbox"/>
Gallstones	_____	Seizures	_____ <input type="checkbox"/>
Cancer	_____	Change in Weight	Gain _____ Loss _____
		If change in weight	_____ lbs _____ time

Please Describe:

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**Have Any Family Members had any of the following?**

	Yes/No		Who
Depression	_____	<input type="checkbox"/>	_____
Bipolar Disorder	_____	<input type="checkbox"/>	_____
Suicide	_____	<input type="checkbox"/>	_____
Schizophrenia	_____	<input type="checkbox"/>	_____
Eating Disorder	_____	<input type="checkbox"/>	_____
Anxiety Disorder	_____	<input type="checkbox"/>	_____
Alcohol/Drug Problems	_____	<input type="checkbox"/>	_____
ADHD	_____	<input type="checkbox"/>	_____
Thyroid Problems	_____	<input type="checkbox"/>	_____
Asthma	_____	<input type="checkbox"/>	_____
Diabetes	_____	<input type="checkbox"/>	_____
Stroke	_____	<input type="checkbox"/>	_____
Dementia/Senility	_____	<input type="checkbox"/>	_____
Stomach Problems	_____	<input type="checkbox"/>	_____
Seizures (type?)	_____	<input type="checkbox"/>	_____
Heart Problems (type?)	_____	<input type="checkbox"/>	_____
Cancer	_____	<input type="checkbox"/>	_____
Tics	_____	<input type="checkbox"/>	_____

Have there been hospitalizations for any medical reasons such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Current Medications (including any over the counter or herbal preparations)

Name of Medication	Dosage	For what reason?	How Long?	Side Effects (if any)

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Other psychiatric medications taken in the past:

Name of Medication	Dosage	For what reason?	How Long?	Side Effects (if any)

Past Psychiatric care (including psychiatrist, psychologist, social worker, nurse, or psychological testing).

Reason	Dates	Type of Treatment	Provider	Hospitalization?

Currently using caffeine?  Yes  No If yes, how much, how often \_\_\_\_\_  
 Currently using cigarettes?  Yes  No If yes, how much, how often \_\_\_\_\_  
 Currently using alcohol?  Yes  No If yes, how much, how often \_\_\_\_\_

\_\_\_\_\_

**Signature** **Date**

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**CUSTODIAL INFORMATION**

**Brief Description of Custodial Arrangements:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Due to the complexity of the marital structure and the implicit issues that arise during and following the process of a separation and divorce, it is required that a single adult be responsible for all appointments and billing.

If legal documents exist regarding custodial agreements it is required that a copy be on file with my office and that the identified parent responsible for scheduling and billing update this as required.

I understand that if I am unwilling or unable to follow this agreement, ongoing care will need to be transferred to an alternate treatment provider.

Parent Contact

Responsible for appointment scheduling and billing: \_\_\_\_\_

Preferred Contact Information: \_\_\_\_\_

Parent Signatures: \_\_\_\_\_

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

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

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**NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ understand that my information is confidential and that I have reviewed my HIPAA privacy statement to ensure the standards the practice uses to safeguard my records.

*I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

The 5 page copy of our Privacy Practice is available to you upon request. Most patients have been familiarized in the HIPAA act as they are affiliated with other entities that are guarded by these standards as well (pharmacies, other physicians, dentists, etc....).

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**2010 FEE SCHEDULE AND PAYMENT AGREEMENT**

- **Adult Initial Evaluation:** This consists of both an initial 55 minute session (\$225) and a second 45 minute session (\$195) follow-up session, review of records, report preparation, correspondence with referring physicians, schools or other agencies as requested, and administrative time.
  
- **Child Initial Evaluation:** This includes an initial 55 minute session with the parents alone (\$225) followed by an individual 45 minute sessions with the child (\$195), and a 45 minute feedback session with the parents and child together (\$195). This also includes any necessary review of records, report preparation, correspondence with referring physicians, schools or other agencies as requested, and administrative time.
  
- **Individual psychotherapy**  
45 minute session                      **\$195**
  
- **Family or Couples Therapy**  
45 minute session                      **\$195**  
80 minute session                      **\$280**
  
- **Medication Management**  
20 minute session                      **\$130**
  
- **Phone Consultation**  
First 10 minutes                      **No charge**  
(during business hours)  
Subsequent 15 minutes                      **\$60**
  
- **School/Home Visit**  
Per hour (including travel)                      **\$195**
  
- **Production of requested report or correspondence**  
Per Hour                      **\$195**

**FEE AGREEMENT**

I understand that all fees are due as stated at the time of services rendered. I agree to accept full financial responsibility for any missed appointments with less than a 48-hour notice. The missed appointment fee is the full fee of the missed appointment and will not be reimbursed by my insurance company. I have carefully read all the terms of the above guidelines and have had the option of discussing any questions or concerns.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

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**CREDIT CARD POLICY**

To my patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company as it makes checkout faster, easier, and more efficient.

I have a similar policy. You will be asked for a credit card number at the time of check in or check out and this information is held safely and securely until you accrue a balance. At this point you may satisfy the balance in whichever format you prefer. However, ANY remaining balance may be charged to your credit card. This method is typically a safeguard for the office and will only be charged if necessary.

This is an advantage to you, since you will no longer have to write out checks or carry cash equivalents. It will be advantageous to me as well since it will greatly decrease the number of statements that I have to generate and mail out. The combination will benefit everyone in helping reduce the cost of healthcare.

If you have any question about this payment method, please do not hesitate to ask.

Sincerely yours,  
Kevin H. Spicer, MD

I authorize Kevin H. Spicer, MD to charge outstanding balances on my account to the following credit card:

Visa                                       MasterCard

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Name on card (please print) \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**