Cumberland Plastic Surgery, P.C.

John David Rosdeutscher, M.D.

Certified Diplomate: American Board of Otolaryngology
Certified Diplomate: American Board of Plastic Surgery

Thank you for choosing Cumberland Plastic Surgery, P.C. as your health care provider. We are dedicated to providing you with the best possible care and service and regard your understanding of our office policies as an essential element of your care and treatment. To assist you we have summarized the following office policies. If you have any questions after reviewing these, please feel free to discuss them with a member of our staff.

OFFICE HOURS: Our office hours are Monday –Thursday from 9:00 a.m. until 4:30 p.m. and Friday from 9:00 a.m. until 12:00 a.m. Appointments may be made by calling (615) 467-3977. We make every effort to see each patient at the scheduled appointment time. However, unscheduled emergencies can occur and we ask for your understanding should that occur. If it's after normal business hours and you have an emergency, please go to the nearest emergency room. If you have an urgent matter, please call our office and follow the prompt.

PRESCRIPTION REFILLS: Our office will only accept requests for prescription refills during normal office hours. It will be your responsibility to notify us in a timely manner.

YOUR INSURANCE: We have contracts with many insurers and health plans. We will bill those plans with whom we have a relationship and will collect any required co-payments at the time of service. In the event your health plan determines a service to be "not covered" you will be responsible for the charge. In that event we will bill you and payment is due upon receipt of that statement. It is important that you give us accurate and timely information about your insurance if we are to bill them for you. If your insurance plan requires that you obtain a referral from your primary care physician before seeing a specialist, it is your responsibility to make certain that referral is sent to us before your visit.

YOUR RESPONSIBILITY: By signing below, you acknowledge that you have read and understand the policies of the practice and agree to be bound by them. You also authorize us to bill your insurance company and to release to them such information as may be needed to process the claims submitted on your behalf. You also accept responsibility for any balance due on your account that is not covered by your insurance. Further, should your account be placed for collection, you will be responsible for any collection fees, attorney fees or court costs.

Signature_____Date_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Cumberland Plastic Surgery, P.C., Dr. John David Rosdeutscher, M.D., and staff to use and disclose **Protected Healthcare Information** (PHI) about me to carry out **Treatment**, **Payment** and **Other** health care operations (TPO). Cumberland Plastic Surgery's Notice of Privacy Practices provides a more complete description of such uses and disclosures; I have the right to review the Notice of Privacy Practices prior to signing this consent.

I (circle one) **DO / DO NOT** want to receive a copy of Dr. John David Rosdeutscher's Notice of Privacy Practices.

With this consent Cumberland Plastic Surgery, and Dr. John David Rosdeutscher, may call my home or other alternative locations regarding any items that assist the practice in carrying out treatment, payment and other healthcare options. This includes appointment reminders, patient statements, and any calls pertaining to my clinical care. I have the right to request that Cumberland Plastic Surgery, John David Rosdeutscher, M.D. restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and other healthcare options. However, 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 Cumberland Plastic Surgery, P.C., and John David Rosdeutscher, M.D. to use and disclose my protected healthcare information in the course of my treatments. 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 consent, or later revoke it, Cumberland Plastic Surgery, and John David Rosdeutscher, M.D. may decline to provide treatment to me.

Due to patient confidentiality laws it is impossible for our office to share your medical information with your immediate family members unless you instruct us otherwise. Please fill out the information below if there is anyone that you would like us to share your information with.

If no one is listed below we will not give any of your information to anyone but you.

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

_____

Patient/Guardian Signature Date

Name _____Date_____

Do you have any medication allergies? Yes No
If yes, please list _____

Are you taking any medications? Yes No
If yes, please list _____

Have you had <u>ANY SURGERIES</u>? (Major or minor surgeries, including mole removal, corrective eye surgery, etc.) Yes No
If yes, please list each surgery and year it occurred: _____
_____

Have you ever been diagnosed with any of the following illnesses?
(Please circle yes or no)

Arthritis/Gout	Yes	No	AIDS/HIV	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Frequent Kidney Problems	Yes	No
Epilepsy	Yes	No	Leukemia	Yes	No
Bleeding Disorder	Yes	No	GI Disorder	Yes	No
Pulmonary Disease	Yes	No	Congenital Abnormalities	Yes	No
Stroke	Yes	No	Heart Disease	Yes	No
Mental Disorder	Yes	No	Depression/Anxiety	Yes	No

If you answered yes to any of the above illnesses, please explain: _____

Have any of the above illnesses been diagnosed in:

Mothers Health History	Yes	No	if yes, please list _____
Fathers Health History	Yes	No	if yes, please list _____
Brother/Sister	Yes	No	if yes, please list _____

Mother:	Living	Deceased	Cause of Death _____
Father:	Living	Deceased	Cause of Death _____
Brother:	Living	Deceased	Cause of Death _____
Sister:	Living	Deceased	Cause of Death _____

Do you exercise? Yes No how many times a week? _____

Do you smoke? Yes No if yes, how much? _____

Do you drink? Yes No if yes, how much? _____

Race	* Multiple selections allowed
American Indian or Alaska Native	☐
Asian	☐
Native Hawaiian or Other Pacific Islander	☐
Black or African American	☐
White	☐
Hispanic	☐
Other Race	☐
Unreported/Refused to Report	☐

Ethnicity: Hispanic _____
Non-Hispanic _____
Rather not say _____

Preferred language: _____

Did a physician refer you to our office? YES NO
If yes, who? _____

Who is your primary care physician? _____

Do you see any other physician on a regular basis? _____
If you answered yes, for what reason _____

Please list any problem or concern that we may need to be aware of _____
_____

Do you have a living will or a power of attorney? Yes No
Name: _____
Relationship to Patient: _____

Do you have any religious beliefs that we should be aware of? Yes No
If you answered yes, please explain _____

I, _____ hereby authorize Dr. John David Rosdeutscher and his staff to examine and perform diagnostic procedures and provide other care necessary to diagnose and/or treat my condition. I understand any pictures taken if they do not reveal my identity may be used for advertising, or medical display.
I understand that unless submitted in writing, this office may leave messages on my answering machine or voice mail at the numbers I have given them.

Signature of Patient or Responsible Party _____
Date _____