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.

Patient / Legal Guardian Signature: _____ Date: ___/___/_____

ABN: ADVANCE BENEFICIARY NOTICE

The purpose of ABN is to give you advance notice that your insurance may not cover these services.

What is medical necessity? Insurances only cover those services that are reasonable and necessary for your treatment. Medicare and other insurances require providers to report information regarding the diagnosis when seeking payment so they can determine whether services rendered were medically necessary. ***Even though your insurance company is alerted to any procedure done by our physician they do not guarantee payment.*** Payment is made after service is rendered and even when pre-authorization/pre-certification is received it does not guarantee payment. Insurance companies state approval is based upon review of medical services after services are rendered.

If your insurance will not pay, does that mean you do not need that service? No. The doctor bases decisions on a wide range of factors including your personal medical history, any medication you might be taking, and generally accepted medical practices. Even if the doctor believes a particular test/service is "good medicine", or useful information to have in order to provide the best care for you, it is possible your insurance may not consider the service medically necessary for patients with your diagnosis and then deny payment of these procedures.

By signing below you understand our office will make every attempt to submit all information required by your insurance company, but please also understand that the final decision is up to your insurance company. If they deny coverage, you will then be held responsible for the cost of the procedure/test that was done.

Patient / Legal Guardian 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.

1. Party's Full Name: _____ Phone: (____) ____-_____

Relationship to Patient: _____

2. Party's Full Name: _____ Phone: (____) ____-_____

Relationship to Patient: _____

Patient / Legal Guardian Signature: _____ Date: ___/___/_____

PATIENT REGISTRATION

MR#_____

Patient Full Name: _____ Date of Birth: ___/___/_____
Address: _____ City: _____ State: ___ Zip: _____
SSN: ____-___-_____ Sex: (M) (F) Marital Status: (Married) (Single) (Divorced) (Widowed)
Cell Phone: (____) ____-_____ Home Phone: (____) ____-_____
Email Address: _____
Employer Name: _____ Phone: (____) ____-_____
Pharmacy Name: _____ Phone: (____) ____-_____
Primary Care Physician / Referring Dr _____ Phone: (____) ____-_____

PERSON RESPONSIBLE FOR BILL

Party's Full Name: _____ Phone: (____) ____-_____
Address: _____ City: _____ State: ___ Zip: _____
Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ I.D.number: _____ Group Number: _____
Policy Holder Name (if different than patient): _____
Relationship to Patient: _____
Policy Holder SSN: ____-___-_____ Date of Birth: ___/___/_____ Sex: (M) (F)

SECONDARY INSURANCE INFORMATION

Plan Name: _____ I.D.number: _____ Group Number: _____
Policy Holder Name (if different than patient): _____
Relationship to Patient: _____
Policy Holder SSN: ____-___-_____ Date of Birth: ___/___/_____ Sex: (M) (F)

EMERGENCY CONTACT

Party's Full Name: _____
Address: _____ City: _____ State: ___ Zip: _____
Cell Phone: (____) ____-_____ Home: (____) ____-_____ Work: (____) ____-_____
Relationship to Patient: _____

IS THIS VISIT DUE TO AN ACCIDENT?

WORK COMP___ AUTO___ OTHER: _____

I authorize the release of any medical information necessary to process any claim to my insurance company, and request payment of benefits to Cumberland Plastic Surgery, P.C. and or John D. Rosdeutscher, M.D..

Patient / Legal Guardian Signature: _____ Date: ___/___/_____

MEDICAL HISTORY

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 ANY SURGERIES? (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? _____

Ethnicity: multiple selections allowed*
___American Indian or Alaska Native
___Asian
___Native Hawaiian or Other Pacific Islander
___Black or African American
___White or Caucasian
___Hispanic
___Other Ethnicity
___Unreported/Refused to Report

Preferred language: _____

Do you see any other physician on a regular basis? Yes No
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.

Patient / Legal Guardian Signature: _____ Date: ___/___/_____