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_____