Medical, Social, Family History and Review of Systems

First: _____ Middle Initial: _____ Last: _____ Jr/Sr: _____

Date of Birth: _____ Pharmacy: _____

Primary Care Doctor: _____ **Referring Doctor: _____**

Do you have a POA (Power of Attorney): yes / no **POA Name & Phone: _____**

Emergency Contact: _____ Phone #: _____ Relation: _____

I authorize Cumberland Dermatology to electronically import my medications (circle) Yes No

Past Medical History: ***Please Check Yes or No***			**Past Surgical History:** ***Please Check Yes or No***					
Do you have a history of:	Y	N		Y	N		Y	N
Arthritis			Colon: (Colectomy) Colon Cancer Resection			Prostate (Prostatectomy)		
COPD			Rectum: APR (Abdominoperineal resection)			Spleen (Splenectomy)		
Depression			Breast: Breast Biopsy			Skin: Skin Biopsy		
Diabetes			Prostate (Prostatectomy): Prostate Biopsy			Liver Resection/Hepatectomy		
End Stage Renal Disease			Gallbladder (Cholecystectomy)			Kidney: Nephrectomy		
HIV/AIDS (Human Immunodeficiency virus)			Bladder (Complete Cystectomy)			Testicles (Orchiectomy)		
High Cholesterol (Hypercholesterolemia)			Heart: Coronary Artery Bypass Surgery			Total Hip replacement-Left		
Leukemia			Ovaries (Oophorectomy): Ovarian Cyst			Total knee replacement-Left		
Lymphoma			Colon: (Colectomy) Diverticulitis			Total Hip replacement-Right		
Colon Cancer (Malignant tumor of colon)			Kidney: Kidney Transplant			Total Knee replacement-Right		
Anxiety			Skin: Basal Cell Carcinoma			Liver Shunt (TIPS)		
Asthma			Skin: Melanoma			Heart: Heart Transplant		
Atrial fibrillation (Irregular heartbeat)			Skin: Squamous Cell Carcinoma			Liver: Liver Transplant		
Enlarged Prostate (BPH)			Ovaries: Tubal Ligation History			OTHER:		
Pacemaker			Heart Biologic Valve Replacement/Graft			OTHER:		
Immunosuppression			Appendix (Appendicectomy)			OTHER:		
Seizures			Prostate (Prostatectomy): TURP			OTHER:		
Coronary Artery Disease			Uterus (Hysterectomy)			OTHER:		
Elevated Blood Pressure			Colon:(Colectomy) Inflammatory Bowel Disease			OTHER:		
GERD (Acid reflux)			Kidney: Kidney Biopsy			OTHER:		
Hearing Loss			Kidney: Kidney Stone Removal			OTHER:		
Hyperthyroidism (overactive thyroid)			Rectum: Lower Anterior Resection			OTHER:		
Hypothyroidism (underactive thyroid)			Breast: Lumpectomy, Left			OTHER:		
Hepatitis			Breast Lumpectomy, Right			OTHER:		
Lung Cancer			Breast Mastectomy Left			OTHER:		
Breast Cancer			Breast Mastectomy Right			OTHER:		
Prostate Cancer			Heart: Mechanical Valve Replacement			OTHER:		
Radiation therapy treatment			Ovaries (Oophorectomy)			OTHER:		
Bone Marrow Transplant (BMT)			Pancreas: Pancreatectomy			OTHER:		
Other:			Heart: PTCA			OTHER:		

If patient is unable to make medical decisions independently, a POA must be present at each visit.

Do you have a history of:	Y	N		Y	N		Y	N
Acne			Eczema			Family History of Melanoma		
Actinic Keratosis			Hay Fever / Allergies			If Yes, Which Relative?		
Asthma			Melanoma			Tanning Salon		
Basal Cell Skin Cancer			Psoriasis			Do You Wear Sunscreen?		
Dry Skin			Scalp Itchy/Flaky			If Yes, What SPF? **(circle)**		
Poison Ivy (Contact Dermatitis)			Squamous Cell Skin Cancer			SPF 15 SPF 30 SPF 45		
Precancerous Moles (Dysplastic nevus)			Sunburn-Blistering			Other:		

******PLEASE CONTINUE ON REVERSE SIDE******

Medical, Social, Family History and Review of Systems

DATE OF RECENT **FLU VACCINATION:**

DATE OF RECENT **PNEUMONIA VACCINATION:**

PRESCRIPTIONS / OVER-THE-COUNTER MEDICATIONS:				**ALLERGIES TO MEDICATIONS:**
Name	**Dose**	**Frequency**	**Route**	

Review of Systems: ***(Past Several Months)*** ***Please Check Yes or No***

	Y	N		Y	N		Y	N
Artificial Joints within past 2 years			Blurry Vision			Thyroid Problems		
Pregnancy or planning a pregnancy			Chest Pain			Unintentional Weight Loss		
Yeast Infections with antibiotics			Cough			Wheezing		
GI Upset with antibiotics			Depression			Pacemaker		
Problems with Bleeding			Fever or Chills			Defibrillator		
Problems with Healing			Headaches			Artificial Heart Valve		
Problems with Scarring (Keloid)			Heart Biologic Valve Replacement/Graft			Premedication		
Immunosuppression			Joint Aches			Allergy to Adhesive		
Changing Mole			Muscle Weakness			Allergy to Topical Ointment		
Rash			Neck Stiffness			Blood Thinners		
Abdominal Pain			Night Sweats			Allergy to Lidocaine		
Anxiety			Seizures			Rapid Heart Beat with Epinephrine		
Blood Stool			Shortness of Breath			Other:		
Bloody Urine			Sore Throat			None of the Above		

Social History: ***Please Check Yes or No***

	Y	N			
Do you drink alcohol?			Smoking Status: (circle one)		
If Yes, Number of Drinks Per Day			***Never Smoker*** ***Current Smoker*** ***Former Smoker***		
How many times in the past year have you had 5 or more drinks in a day (for men), or 4 or more drinks in a day (for women) or any adult older than 65?			If current smoker, how many packs per day?		
			If former smoker, date you stopped?		

Cumberland Dermatology

If patient is unable to make medical decisions independently, a POA must be present at each visit.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. This health form will expire three (3) years from date signed and will require a new form be completed.

Patient's Signature _____ **Date** _____

Cumberland Dermatology

PATIENT REGISTRATION

Name: _____
FIRST MIDDLE LAST

Date of Birth: _____ Social Security Number: _____ Gender: _____

Mailing Address:_____
STREET CITY STATE ZIP

Cell Phone: _____ Home Phone: _____
Which number is primary? *CELL or HOME* **Are we allowed to leave detailed messages? *YES or NO***

E-Mail Address: _____
Providing your e-mail will opt you in for e-mailed appointment reminders and office promotions/newsletters. You may opt out by calling our office or within the e-mail by clicking the Unsubscribe link

Guarantor Name: _____ Guarantor DOB: _____ Relationship to Patient: _____

Employer: _____ Employer Phone: _____

Marital Status: ***(circle)*** Single Married Separated Divorced Widowed

Race: ***(circle)*** American Indian Alaska Native Native Hawaiian African American White
Asian Pacific Islander Other: _____

Ethnicity: ***(circle)*** Not Hispanic or Latino Hispanic/Latino Unknown Decline to Specify

Language: ***(circle)*** English Spanish Other: _____

If you change insurance carriers or you are issued a new card, it is your responsibility to provide the new card to our office.

After your visit today, you will have access to an online Patient Portal where your complete medical record can be viewed. You may obtain your log-in information at your visit from staff or by e-mailing us at cderm@cumberlandderm.com. If you provide your e-mail address, we can automatically do this for you.

Please review and sign: I authorize Cumberland Dermatology for treatment. I also authorize the release of any information acquired in the course of the examination and treatment to secure payment of claims and benefits. I authorize payment directly from my insurance company (if applicable) to Cumberland Dermatology. I agree to be responsible for any deductibles, copays, coinsurances and services rendered that are not covered by my insurance plan.

_____
Signature of Patient or Patient Representative Date

Cumberland Dermatology

O F F I C E F I N A N C I A L P O L I C Y

We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered to you by this office. It is necessary that you provide accurate and updated information when you are seen for services that can be billed to your insurance**. If your insurance requires a referral or prior authorization, it is your responsibility to make sure we have that from your doctor or insurance company.** This information must be in this office prior to your being seen. If you arrive for an appointment and have an insurance that requires such paperwork, you will not be seen if it is not present.

- On the day of your appointment, you will be responsible for the following:
    - **Co-Payments, Co-Insurance, Insurance Deductibles**
    - **Charges for non-covered services or cosmetic procedures**
    - **Payment in full if you are Self-Pay or have an Out of Network insurance**
- If your deductible has not been met or you have an out of network insurance carrier, we will collect payment in full and process a refund, if applicable, once the claim processes.
- **It is your responsibility to make sure your primary insurance is aware of your secondary insurance and that it is set up to cross over automatically. WE CAN NOT DO THIS FOR YOU.**
- All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. It is your responsibility to provide accurate and current insurance information and to keep your file updated with that information. If you fail to provide correct insurance information at the time of your appointment and it results in a claim denial, you are responsible for payment of these services. If you attempt to provide insurance information at a later date, it may or may not be accepted. Most insurances have a time limit of filing claims. **If we are unable to collect from your primary or secondary insurance within three (3) months the balance will be turned over to you the patient.**
- Billing statements are mailed after your claim processes and the balance is due within 30 days of receipt.
- Unpaid balances will receive a late notice and will be turned over to a collection agency if not paid within 30 days of the late notice. Once an account is turned over to collections, all communications will be with the collection agency. After your balance is paid with the collection agency, you will be required to pay in full at every visit thereafter. Once your insurance processes, we will issue a refund for any credit on the account. Patients who are in collection status and do not bring their account current may be discharged via certified letter from Cumberland Dermatology with availability only for emergency care 30 days following dismissal. **Accounts sent to collection will be assessed a fee equal to 15% of the balance due or $150.00, whichever is greater.**
- We will not accept insurance cards that have been altered or tampered with in any way.
- We will ask to scan and verify your insurance cards once a year. If you have changes to your insurance coverage you must inform the registration staff and provide a copy of the new card.
- We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and Care Credit. Use of Care Credit requires a minimum transaction amount of $100.00. Returned Checks will be subject to a $30.00 fee which will be added to the balance due. Once a patient balance is determined, a statement will be mailed to the address which was provided to us.
- Should you require a surgical procedure, you will be given a quote for these services in relation to your insurance coverage. It is your responsibility to determine payment arrangements as this will be collected on the day of your procedure. **You will be asked to sign this document every three (3) years.**

_____ _____

PATIENT SIGNATURE DATE

Cumberland Dermatology

KENDALL ANNE MORRISON, MD

JUSTIN BELL, NP-C • BROOKE HUFF, PA-C • JESSICA ROTOLO, PA-C • NICK PARKER, PA-C

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

I have read and understand Cumberland Dermatology's Notice of Privacy Practices. I acknowledge that I may request and will be provided a copy at any time from the office. I also understand that I am able to take the copy with me that I read prior to signing this notice.

_____

Signature of Patient or Patient Representative

_____

Print Name of Patient or Patient Representative *Patient Date of Birth*

_____

Today's Date

Who are we allowed to talk to about your medical treatment?

↓ TELL US HERE ↓

I authorize the disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ **Relationship:** _____

Phone: _____

Name: _____ **Relationship:** _____

Phone: _____

This authorization shall be in force and effect for thirty-six (36) months at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time prior to the planned expiration date.

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual Refused to sign ❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgements

❒ Other (Please Specify) _____

PRACTICE INFORMATION

YOUR APPOINTMENT

Your time is important to us. Your appointment was scheduled based on the **reason you gave us** when you scheduled. If you have additional problems or need to discuss other concerns with your provider, we will have to schedule a separate appointment to address these problems / concerns. This will allow us to be considerate of other patient appointments.

CONFIRMING YOUR APPOINTMENT

Due to the high demand for dermatology appointments and frequent no-shows, we do require you to confirm your appointment two to three days prior to your scheduled visit**. If an appointment is not confirmed, it will be canceled.** As a courtesy, we work to confirm your appointments by using e-mail, text messaging and/or a phone call from our online appointment scheduling software. We know how easy it is to forget an appointment you booked months ago. With our current system you have the option of the following:

- confirm your appointment from the link provided in the **e-mail**;
- confirm your appointment by responding **with the number 1** to the **text**;
- confirm your appointment by phone using the appropriate selection prompts;
- call our office at #931-484-6061 to cancel, makes changes, or to confirm directly

Please understand that it is your responsibility to remember your appointment dates and times. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment.

LATE ARRIVALS

Out of respect for other patients arriving on time, if you arrive more than 15 minutes late, you may be asked to reschedule. However, arriving less than 15 minutes late DOES NOT guarantee that you will be seen. It is at the discretion of your health care provider whether you can be worked back in to the schedule. If you have not signed in within five (5) minutes of your appointment time, someone from the office will call to verify if you are still planning on keeping your appointment.

YOUR PRESCRIPTIONS

Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. This often means that your prescription will not be ready for pickup until the end of the day. We strongly suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of "preferred drugs". We try very hard to keep current with these changes. However, you may find that your insurance company has rejected your prescription because it is not on their "preferred list". Again, we suggest you call your pharmacy to make sure your prescription(s) are ready before going to pick them up. If your prescription is rejected by your insurance because it is not on their "preferred list", additional time will be required for approval of a substitute medication.

CANCELLATION / NO-SHOW POLICY

We respectfully ask for 24 hours' notice if you will be unable to keep an appointment. If you have more than three (3) no-show occurrences, you may be discharged from the practice**. PROCEDURES:** If you no show or cancel an appointment for a procedure with less than a 24 hours' notice (including Mohs, BOTOX, fillers, Microneedling, excisions, ED&C or LN2) you will be subject to a $50.00 non-refundable cancellation fee that must be paid prior to rescheduling. If you miss two procedures without proper notice within a 12-month period, you may be discharged from the practice for non-compliance.

PAYMENTS DUE AT TIME OF SERVICE

Co-pays, co-insurance, deductibles and payment for cosmetic services rendered are expected at time of visit.

CONSENT TO TREAT MINORS

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments.

CONSENT TO LEAVE MESSAGES / PATIENT ACCESS

By completing the consent below, you are allowing the providers and staff of Cumberland Dermatology to leave a message on an answering machine, voicemail or with a specified individual (per your HIPAA release). By signing, you are also consenting to the mailing, e-mailing, texting or faxing of any results or appointment information to you or your primary care physician or another physician involved in your care. You may view your medical record by using our secure patient portal. If you provide an e-mail address, we will send you an activation link to gain entry.

Patient Name (please print):_____ **DOB:** _____

Patient Signature:_____