Cumberland Medical Associates, PC

PATIENT INFORMATION

Name: Last: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: ____/____/_____ Date of Birth: ____/____/____ Home: _____ Cell: _____

Sex: ☐ Male ☐ Female **Race:** ☐ White ☐Black ☐ Hispanic ☐Asian ☐Other: _____

Martial Status: ☐Married ☐Single ☐ Separated ☐ Divorced ☐ Widowed

Employer: _____ Work Phone Number: _____

Address: _____ Occupation: _____

Insurance:
Primary: _____ Secondary: _____ Third: _____

Responsible Party Information:

Name: Last: _____ First: _____ Middle: _____

Address: _____ HM: _____ Cell: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other: _____

Name of Nearest Relative not living in Household: _____

Address of Relative: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Relationship to Patient: _____

I understand that the insurance benefits are provided directly for the patient/guarantor, furthermore I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **Cumberland Medical Associates, PC.** If for any reason I fail to meet my financial obligations to Cumberland Medical Associates, PC, and forcing Cumberland Medical Associates, PC to seek Court actions as a means of collection, I understand that I will be responsible for the balance due on my account plus all court processing fees.

General/Consent for Treatment: This is to certify that I (we) the undersigned voluntarily consent to the administration and performance of diagnostic procedure/imaging/photography and medical treatment by authorized agents and employees of Cumberland medical Associates, PC as may, in their professional judgment be deemed necessary of beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to that no guarantees have been made to me (use as the effect of such examination or treatment.

I further authorize **Cumberland Medical Associates**, PC. Physicians, staff, or agents to contact me at my home phone number (or designated number). If I am not available, I authorize my spouse, child, sibling, parent, or caregiver at the same phone number and any applicable patient information to any physician/service/practice my physician is referring me to for further treatment.

Authorization to Release Medical Associates Information: I, _____ hereby authorize **Cumberland Medical Associates, PC** to release the medical records and/or other information, including copies concerning treatment of the above signed, for the purpose of obtaining approval and processing claims for payment for medical expenses incurred:

- Physician referrals for continuation for medical care
- Governmental agencies or programs, managed care organizations and/or insurance companies.
- The utilization review organization contacted by my employer, insurance company or governmental agency or program, or to physicians or other health care institutions responsible for further car or follow-up treatment to server the goal of continuation for my care. The authorization includes the release of medical records and/or information concerning drug related conditions, alcoholism, psychological, psychiatric condition, and/or communicable disease (including AIDS), if applicable.

X_____ _____

Signature of patient/Parent or Legal Guardian of Minor Date

ARE YOU HAVING ANY OF THE FOLLOWING PROBLEMS?

Yes	No		Yes	No	
☐	☐	More than 20 lbs weight change in 3 months	☐	☐	Blood in stool
☐	☐	Persistent blurry vision	☐	☐	Incontinence of urine
☐	☐	Difficulty hearing	☐	☐	Abnormal moles on skin
☐	☐	Chest Pain	☐	☐	Blood transfusion in the past
☐	☐	Significant trouble breathing	☐	☐	Thoughts of suicide or hurting yourself

ALLERGIES

Drug	Reaction

MEDICATIONS

What medications are you taking (including birth control pills and drugs you buy without prescription)?

Drug	Dosage	Directions

PAST MEDICAL ILLNESSES

(Illness you have had PREVIOUS to visit)

Yes	No		Yes	No		Yes	No	
☐	☐	Irregular heart Beat	☐	☐	Gallstones	☐	☐	Diabetes/High Blood Sugar
☐	☐	Congestive heat Failure	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Heart Attack	☐	☐	Ulcers in bowels/Stomach	☐	☐	Anemia/Low Blood
☐	☐	Blood clot in Leg	☐	☐	Bleeding from Bowels	☐	☐	Bleeding Problems
☐	☐	High Cholesterol	☐	☐	Kidney Disease	☐	☐	Blood Transfusion
☐	☐	High Blood Pressure	☐	☐	Kidney Stones	☐	☐	Cancer
☐	☐	Heart Murmur	☐	☐	Prostate Problems	☐	☐	Anxiety
☐	☐	Rheumatic Fever	☐	☐	Gout	☐	☐	Depression
☐	☐	Asthma	☐	☐	Arthritis	☐	☐	Glaucoma
☐	☐	Emphysema/ Bronchitis	☐	☐	Skin Disease	☐	☐	Other
☐	☐	Blood Clot in Lung	☐	☐	Stroke			_____
☐	☐	Tuberculosis	☐	☐	Epilepsy/Seizures			

Number of Pregnancies _____ Number of Deliveries _____ Number of Elective Abortions_____ Number of Miscarriages_____

Form of Birth Control: _____ When was your last Pap smear? _____ Have you ever had an abnormal Pap smear? ☐ Yes or ☐ No

If "Yes" when was the abnormal Pap smear? _____ What was the abnormality? _____ Kind of Treatment? _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? ☐ Yes or ☐ No

If "Yes" when was the abnormal Mammogram? _____ What additional testing or treatment did you have? _____

Surgery

Yes	No		Date	Yes	No		Date
☐	☐	Appendectomy	_____	☐	☐	Joint Replacement	_____
☐	☐	Joint Scope Surgery	_____	☐	☐	Back Disk Surgery	_____
☐	☐	Biopsy of:	_____	☐	☐	Abdominal Surgery	_____
☐	☐	Open Heart Surgery	_____	☐	☐	Tonsils Removed	_____
☐	☐	Neck Artery Surgery	_____	☐	☐	Prostate Surgery	_____
☐	☐	Cataract Surgery, R or L	_____	☐	☐	Vasectomy	_____
☐	☐	Gallbladder	_____	☐	☐	Hysterectomy	_____
☐	☐	Broken Bone Repair	_____	☐	☐	Other:	_____

Other Specialty Doctors You See

Specialty	Name	Location	Telephone

Family History

(Disease affection your parents and /or your brothers and sisters only)

Yes	No		Yes	No	
☐	☐	Heart Attack	☐	☐	Bleeding Problems
☐	☐	High Blood Pressure	☐	☐	Sickle Cell Anemia
☐	☐	High Cholesterol	☐	☐	Diabetes/High Blood Sugar
☐	☐	Asthma	☐	☐	Thyroid Problems
☐	☐	Tuberculosis	☐	☐	Cancer, Type: _____
☐	☐	Liver Disease	☐	☐	Cancer, Type: _____
☐	☐	Kidney Disease	☐	☐	Alcohol Abuse
☐	☐	Osteoporosis	☐	☐	Anxiety or Depression:
☐	☐	Stroke	☐	☐	Glaucoma
☐	☐	Epilepsy/ Seizures	☐	☐	Other: _____

Social History

Exercise: ☐Never ☐Rarely ☐Daily **Primary Language if not English:** _____

Current Employment: ☐ Full-time ☐Part-Time ☐Not Working ☐Retired

Religion: Name any ethic, religious, or cultural beliefs that will influence your treatment: _____

_____

Smoking:

Have you ever smoked: ☐ Yes or ☐ No How many years did you smoke? _____

How many packs per day do you smoke now: _____ Do you use smokeless tobacco: ☐ Yes or ☐ No

(The following questions are important and strictly confidential. Please answer them accurately)

Alcohol/Drugs:

Yes	No	
☐	☐	In the last year, have you ever drunk alcohol or used drugs more than you meant to?
☐	☐	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

What drugs have you used in the past? _____

What drugs do you currently sue? _____

Accurate information is critical to your care.
We will make every effort to safeguard your information.
Thank You for helping us to serve you

Cumberland Medical Associates, PC

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis only.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Insufficient Funds. If for any reason a check is returned for insufficient funds or closed account, patient will be responsible for the amount of the check and a reprocessing fee of $30.00. Payment will be expected within **10 days** from the date of notice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Records Release Form

Patient Name: _____ Birth Date: ___/___/_____
(Print)

Treatment Date: _____ SSN _____/_____/_____

I hereby Consent to and authorize _____ to Release to:

Cumberland Medial Associate, PC
5085 Morganton Rd Ste 100
Fayetteville, NC 28314

Protected health Information (PHI) concerning the history, treatment, examination and/or hospitalization of the above patient, I understand that the specific type of PHI to be release includes:

☐ Discharge Summary ☐ History and Physical ☐ Emergency Department Records

☐ Operative/Procedure Reports ☐ Consultations Reports ☐ Labs, X-Rays EKG's

☐ Others (specify): _____

The purpose for releasing this information is:

_____

☐ I DO ☐ I DO NOT authorize the release of portions of the record relating to substance abuse, psychological/ psychiatric conditions and/or communicable disease, including Acquired Immunodeficiency Syndrome (AIDS), or test for infection with Human Immunodeficiency Virus (HIV), if present.

I understand the following:

My health care and the payment for my health care will be affected by signing this form. The healthcare provider may not condition the provision of health care on the signing of the authorization, except that the healthcare provider may condition the provision of care that is solely for the purpose of creating PHI of disclosure to a third party, upon signing and authorization for disclosure of the PHI for such research.

If the request or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

I may revoke this authorization at any time in writing. Revocation for this release will not have any affect on any actions previously taken. The healthcare provider will provide me with a copy of this signed authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

_____ _____
Signature of Witness Date

This consent will automatically expire **90 days** date of signature, unless another date is specified below:

*Authorization is not valid beyond _____
(Date cannot exceed one year from date of signature)

Imaging Facilities

Listed below are your local
Diagnostic Centers.
Please select your Preference:

Name: _____ DOB: _____

☐ Cape Fear Valley Radiology 1638 Owen Drive Fayetteville, NC 28304 910-615-5116 Phone 910-615-6991 Fax	☐ Carolina Imaging 3628 Cape Center Drive Fayetteville, NC 28304 910-483-1321 Phone 910-829-1382 Fax
☐ Southern Pines Diagnostic Imaging 355 South Bennett Street Southern Pines, NC 28387 877-361-4757 Phone 877-361-4855 Fax	☐ Valley Regional Imaging 3186 Village Drive Fayetteville, NC 28304 910-323-2209 Phone 910-485-3180 Fax
☐ Womack Radiology 4-2817 Riley Road Fort Bragg, NC 28310 910-907-7160 Phone 910-907-8733 Fax	

Wellness Update

Patient_____ **Date of Birth**___/___/_____ **Today's Date**___/___/_____

Do you experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ **Yes** ☐ **No**

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc…)

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

Patient Phone: _____

FOR CAT/CAS USE ONLY:
Date of Last ENT Exam:___/___/_____