REGISTRATION FORM
Cumberland Cardiology, 3505 Village Drive, Fayetteville NC 28304
910-323-0065 Phone

Name:____Marital Status: Mar/Div/Single/Wid.

Date of Birth:__________________Sex: __F__M Primary Care Doctor:_______________________

Address:__________________________________City:_______________State/Zip_______________

Occupation:_______________Employer:_____________Social Sec. No.:______________________

Referred by:____________________________Otherfamily members seen here:_______________

Email:_____________________ Phone No:_______________________Cell:__________________

Pharmacy Name:____________________Location:___________________________________

Person responsible for bill:____

Primary Insurance:____________________________Active Coverage:_______________________

Subscribers Name:____

Address, if different:____

Relationship to patient:_____________Subscribers SSN:_______________DOB_______________

Secondary Insurance:____

Subscribers Name:____

Address, if different:____

Relationship to patient:_____________Subscribers SSN:_______________DOB______________

Name of Friend/Relative not living with you:______________________Phone:______________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I acknowledge that I have listed **ALL** insurance companies that I have medical coverage with. I understand that I am financially responsible for any balance. I also authorize Cumberland Cardiology or insurance company to release any information required to process my claims.

_______________________________________ _________________________________

Patient/Guardian Signature Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Cumberland Cardiology, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Cumberland Cardiology, P.A to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Cumberland Cardiology on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

____ ______________________

Patient/Responsible Party Signature Date

Patient Consent for Disclosure of Information

I authorize the release of my protected health information to the following person(s):

Name:____

Address:____

Phone:_________________ Relation to Patient:______________________

Limitations on the information you may release subject to this Release Form are as follow:____
____
____

I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE _______

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative
of my protected health information, to the person(s) listed above

____
Patient Signature (or Parent, Guardian, or Legal Representative) Date

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, all co-pays and deductibles are due at the time of your visit. Additional financial responsibility maybe determined after your insurance has processed your claim. For your convenience we accept [Visa, MasterCard, Discover, American Express, checks & Cash]. NSF checks will incur a $30.00 fee which will be added to your account balance.

Patient Insurance:

 We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office’s policy is to collect this co-payment when you arrive for your appointment. It is your responsibility to inform us of all of your insurance coverage. If you do not list all of the coverage you have, you will be billed for any charges not covered or revoked due to misinformation.

 If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

 In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

 We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients:

 For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. All patient under the age of 18 will not be seen without a parent or guardian present/or without a signed consent form.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

____

Printed Name of the Patient

____

Signature of Patient or Responsible Party if a Minor Date

PLEASE PRINT CLEARLY
Cumberland Cardiology PA

PATIENT HISTORY FORM

DATE: _____________ **Primary Doctor**: _______________________

Due to patient confidentially information contained here will NOT be released to anyone without your written authorization.

Last Name: ________________________ **First Name:** _______________________________

MEDICAL HISTORY: (High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.)

SURGICAL: (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.) □ NONE

Allergies to medications: □ NONE (If YES, please list medication and explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc,):

CURRENT PRESCRIPTION MEDICATION: OTC MEDICATION: Aspirin, Tylenol, Aleve, Vitamins (herbals). List name of drug, mg does, # tablets, # times per day taken:

Review of Systems:

Do you now or have you had any problems related to the following systems?

Fever	Yes	No
Chills	Yes	No
Headache	Yes	No
Skin rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No

Other

Eyes Musculoskeletal

Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No
Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No

Other

Allergic/Immunologic Ear/Nose/Throat/Mouth

Hay Fever	Yes	No
Drug allergies	Yes	No
Ear infection	Yes	No
Sore throat	Yes	No
Sinus problem	Yes	No

Other

Neurological Genitourinary

Tremors	Yes	No
Dizzy spells	Yes	No
Numbness/tingling	Yes	No
Urine retention	Yes	No
Painful urination	Yes	No
Frequent Falls	Yes	No
Urinary frequency	Yes	No

Other

Endocrine Respiratory

Excessive thirst	Yes	No
Too hot/cold	Yes	No

Tired/sluggish	Yes	No
Wheezing	Yes	No
Frequent cough	Yes	No
Shortness of breath	Yes	No

Other

____

____

Gastrointestinal Hematologic/Lymphatic

Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Indigestion/heartburn	Yes	No
Swollen glands	Yes	No
Blood clotting problem	Yes	No

Other

____

____

Cardiovascular Psychological

Chest pain	Yes	No
Varicose veins	Yes	No
High blood pressure	Yes	No
Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you considered suicide?	Yes	No
Do you have trouble sleeping?	Yes	No

Other:____

____

Do you exercise: ________none________mild_____occasional_____regularly

FAMILY HISTORY

Father: □ Living, age: ________ □ Deceased, age at death: _______ (Cause)

Mother: □ Living, age: ________ □ Deceased, age at death: _______ (Cause)

Siblings: Number living: _______ Number deceased _____________ (Cause)

List other illnesses in your family (example; Diabetes, Heart Disease, Colon Cancer, Breast Cancer, Prostate Cancer, etc)

Family Member Illnesses:

____

____

____

____

____

Social History:

Smoke □ YES / □ NO If yes, how much? _____ # of packs/day _______# of years. When did you stop smoking? _______

Alcohol □ YES / □ NO If yes, how much? _________________________________
Caffeine: □ YES / □ NO If yes, how much? _________________________________

Exercise regularly? □ Yes / □ No If yes, what and how frequently?
____

Substance Abuse? □ Yes / □ No

Patient/Parent Signature: ____