Acct #

E. THOMAS CULLOM, III, M.D., PLLC

PATIENT INFORMATION

Patient: (Last First Middle) Title: Mr./Mrs./Other: Suffix: Jr/Sr/Other:

Mailing Address: (City State Zip)

Home Ph.: Work Ph.: Cell Ph.: Email Address:

Social Security # Date of Birth: Sex: M or F

Employment Status: (circle one) Not Employed Fulltime Unknown Self Employed Retired Part time Military Active Employer:

Marital Status: Married Single Widowed Divorced (circle one) Student: Full or Part time (circle one)

Referred By: PCP:

Is this an accident or Injury? Y or N Date of injury:

Work Related? *Y or N * If Y Responsible Party should be Employer. Date symptoms began:

Emergency Contact Name: Relationship:

Phone: Home: Work: Cell:

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? Y or N
If 'Y', request a Facility Information Form and ask about an ABN form.

RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party: (Employer Info if work related) (Last First Middle) Title: Mr./Mrs./Other: Suffix: Jr/Sr/Other:

Mailing Address: (City State Zip)

Home Ph.: Work Ph.: Cell Ph.: Resp Pty Date of Birth:

Social Security # Resp Pty Sex: M or F Relationship to Patient:

Employment Status: (circle one) Not Employed Fulltime Unknown Self Employed Retired Part time Military Active Employer:

Marital Status: Married Single Widowed Divorced (circle one)

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY:

Policy #: Grp#

Insured: DOB:

Relationship to Patient: Self Child Mate Other (circle one)

SECONDARY:

Policy #: Grp#

Insured: DOB:

Relationship to Patient: Self Child Mate Other (circle one)

By signing this, I hereby acknowledge E. Thomas Cullom, III, M.D., PLLC (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how protected health information is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

Signature Date

I hereby authorize E. Thomas Cullom, III, M.D., PLLC to evaluate and recommend any testing and/or additional treatment.
I understand I have the right to refuse any such recommendations/treatment.

Signature Date

I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date.

I hereby authorize the attached insurance companies to pay directly to E. Thomas Cullom, III, M.D., PLLC benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge outstanding amounts due from me, greater than 30 days, will be assessed a finance charge of 1.5% per month.

Signature Date

PRESCRIPTION REFILLS

Telephone prescription refills must be requested on Monday - Thursday between the hours of 8:30am and 4:00pm.
Please note that **no** medication refills will be called on Fridays or after hours.

Signature Date

E. THOMAS CULLOM, III, M.D., PLLC

Acct #

PATIENT INFORMATION

Patient: Title: Mr./Mrs./Other: Suffix: Jr/Sr/Other:

Last First Middle

If Hospice/HHA/NH/SNF patient and answered 'Y'es on Acquaintance Form, complete below and ask about an ABN form.
Please ask if you have any questions.

FACILITY INFORMATION

Type: (circle one) Hospice Home Health Nursing Home Skilled Nursing Facility

Facility Name: _____ Contact Name:_____

Last First Middle

Mailing Address:

City State Zip

Phone:

OFFICE USE ONLY

Provide ABN form for all services.

If currently a Home Health patient, all charges must be paid for prior to rendering services or the patient must be redirected to the HHA facility for care.