CUMBERLAND INTERNAL MEDICINE

1450 E. Chestnut Avenue - Building 3, Suite A - Vineland, NJ 08361
Phone 856-794-8700 - Fax 856-794-2752

David W. Galetto, M.D. - John C. Ahrens, M.D. - Vakula Atthota, M.D
Badiaa El-Imad, M.D. - Elizabeth Santoro, P.A.

Welcome to Cumberland Internal Medicine.
Thank you for choosing us as your medical care provider. Our doctors are board certified in Internal Medicine and Infectious Disease. A complete comprehensive exam is performed on all new patients establishing care with us. Initial visits are 40-minutes and quite in-depth. Subsequent visits, however, are not as involved and are 20-minutes.

Please take the time to become familiar with some of our policies below.

APPOINTMENTS: We see patients by appointment only. We offer appointments to accommodate different schedules including, early morning, late afternoon, and some early evening appointments. Please be on time for your appointment and sign in upon arrival and have a seat. Our receptionist will call you to the window.

Bring you insurance card, your payment, photo ID and your medications with you each visit.

SAME DAY APPOINTMENTS: We offer same-day scheduling for acute and problem-related visits. We also offer a new type of visit which is called a focus visit. These visits are short visits primarily for urinary tract infections and upper respiratory infections such as, cold symptoms, sinusitis, cough, and sore throat. We are in the process of epaoding the reasons included in the focus visit. For most-of the visit, you will be speaking with the nurse or medical assistant then have a brief examination from the provider. This is a same day appointment created to meet our patient's needs. All appointments mentioned above are usually scheduled with our nurse practitioner.

PREVENTIVE APPOINTMENTS: When scheduling a preventive appointment please make sure that you state what type of appointment you are scheduling. You cannot have a preventive visit the same time as your first initial visit

CANCELLATIONS: Due to the volume of patients, we require 24-hour notice of your inability to keep your appointment. When canceling an appointment, you must speak to a person and get their name. Same day cancellation and no-show foes are $25 for 20-minute appointments and $50 for 40-minute appointments. There also is a $15 no-show fee for med-tech and nurse appointments.

MEDICAL CLEARANCES: Patients are required to bring all necessary paperwork, labs and clearance letters 1liat are required to be filled out before appointment. Han EKG is done elsewhere, we will need it faxed or brought to the office at least 48-hours before your scheduled appt. These appointments are usually scheduled with the nurse practitioner. They should be scheduled at least two weeks before surgery date as you may need follow-up or more extensive clearance (cardiology.)

IMPORTANT INFORMATION: Please provide us accurate and complete infonnation onbowto contact you. This includes a current mailing address, email address, home, work, and cell phone numbers. This is very important for us to reach you when we need to.

TELEPHONE CALLS: We have staff available to answer non-urgent questions between visits. We ask you to leave your message on our nurse line (x57) or follow the telephone prompts. Calls are returned based on urgency. We will return your call within 48hrs. Complicated issues will require an appointment.

PRESCRIPTION REFILLS: We prefer you request all your prescription refills during your office visit. If you need refills between visits, you may request them through our secure patient portal or you may leave your request on our prescription line (x70). **Please allow 48 hours for refills. If your refill is a controlled substance, you may require an appointment. Due to the increasing mandates, controlled substances can take up to a week to refill due to monitoring. Please request accordingly. Please utilize the portal and phone only as walk-ins delay our patient flow.**

INSURANCE POLICY: We accept most insurance plans. However, there are a few that we do not except. Please provide us with accurate and complete insurance information; if you have a change of insurance, it is important that you notify us before your next appointment. Copays, deductibles, and coinsurance balances are due at the time of service. We are not able to waive deductibles, co-insurance balances, or copays. If you are in collections, you will be asked to pay this balance as well.

INSURANCE REFERRALS: Some insurance require that you have a referral prior to seeing a specialist Your doctor may want to see you prior to authorizing a referral. It is your responsibility to be familiar with the requirements of your insurance plan. Please call 1 week prior to needing a referral. Referrals are good for 30-90 days. If you see a specialist without the proper referral. you will be responsible for paying for those services. Our referrals are done electronically making it easier for the specialist to access it on-line. Referrals cannot be back dated.

PAYMENT POLICY: Payment is expected when services are rendered We accept cash, checks, money orders, all debit, and major credit cards. **RETURNED CHECKS:** There will be a $20 fee for any checks returned for any reason. **If you have a check returned, we will only accept cash or a credit card thereafter. FORM FEES:** There will be a $15-$25-dollar fee for forms that need to be completed by the doctor. The difference in price ranges due to the type and length of the form. This cannot be billed to your insurance. You may need to make an appointment to have the form completed If a physical is required in order to complete the form and you have already had one physical exam. for the year, you will be responsible for the exam fee

LAB RESULTS: Follow-up appts are usually scheduled to review lab results. You can also view them on your patient portal, LabCorp or Quest portal.

PATIENT PORTAL: We are an innovated practice. We strive to offer our patients convenient, high-quality care. One of the ways we do this is by offering our patients online health services through our secure patient portal. These services include the ability to request refills, appointments, lab results, and online access to your medical chart. Please sign up at the desk and become familiar with CIM portal!

HOW TO CONTACT US AFTER HOURS: We have a physician on call when the office is not open. This is for urgent or emergency issues only. You may reach our answering service at 856-453-2669 or by calling our main number after the office is closed and then selecting option 1. Always call us first before going to the ER, unless it is a life-threatening emergency. The physician will instruct you on what you should do. **The answering service does not schedule or cancel appointments. Please do not contact us after hours for routine matters or prescription refills.**

RESIDENCY PROGRAM: We are pleased to announce that our physicians contribute to the training of Internal Medicine residents through the accredited residency program. at Inspire Health Network. Residents are medical doctors who are receiving medical training, under our physician's supervision; residents may participate in your care at the hospital and in the office.

We appreciate your attention to these policies. Please do not hesitate to contact our office if you have any questions or concerns.

X _____

Signature/Date

CUMBERLAND
INTERNAL MEDICINE

MEDICAL HISTORY - PRIMARY CARE PATIENT

Name: _____ Age: ____ DOB: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____

Email: _____

** **Preferred method of contact (please circle):** **Home** **Cell** **Email**

Gender Identity: Male Female Transgender Non-Identified

Single Married Divorced Widowed Separated

If married, spouse's name: _____

Children's names & ages: _____

_____

Emergency Contact: _____

Home: _____ Cell: _____

Spouse:_____ Child:_____ Sibling:_____ Friend:_____ Other:_____

Race: Asian:_____ Black:_____ Hispanic:_____ White:_____ Other:_____

Ethnicity:_____

Primary Language Spoken: English:_____ Spanish:_____ Other:_____

Allergies to Medications, Xray Dyes or Other Substances: Yes_____ No_____

** **Please list name of medicine and type of reaction - If multiple list 1 per line, list on back page if needed****

_____

_____

_____

Past Surgeries - please list type of surgery/provider/hospital and date:

1)_____

2)_____

3)_____

Past Medical History

1 High Blood Pressure
2 Diabetes
3 Cancer
Type:_____
4 Heart Disease
5 High Cholesterol
6 Thyroid Disease
7 Asthma
8 Pneumonia
9 TB - Tuberculosis
10 COPD
11 GERD
12 Seasonal Allergies
13 Anxiety
14 Depression
15 IBS
16 Gout
17 CVA/Stroke
18 A-Fib
19 Osteoporosis
20 Arthritis
21 Heart Valve Replacement
22 Mastectomy
23 Pacemaker
24 Joint replacement
25 Use blood thinners
26 Anemia
27 Hemorrhoids
28 Gall Bladder Disease
29 Diverticulitis
30 Colitis
31 Hepatitis or Jaundice
32 Kidney Stones
33 Kidney Disease
34 Lower back problems
35 Skin Diseases
36 Blood Disorders
37 Alcohol abuse
38 Drug abuse
39 Bariatric Surgery

Gynecologic and Obstetric History

Reached menopause? YES____ NO____ If Yes approximate date? _____

Immunization History - you have had:

Hepatitis B YES____ NO____ When _____

Flu YES____ NO____ When _____

Pneumovax YES____ NO____ When _____

Prevnar YES____ NO____ When _____

Tetanus YES____ NO____ When _____

Shingles YES____ NO____ When _____

Other: _____

Medications (Prescriptions, Over-the Counter, Vitamins, Herbs, Supplements, etc.)

Drug Name Dose Drug Name Dose

_____ _____

_____ _____

_____ _____

Social History

Do you drink alcohol: Yes____ No____ How many per day:_____ Per week:_____

Do you currently smoke: Yes____ No____ How many per day:_____ Per week:_____

If you smoke packs: How many per day:_____ Per week:_____

If you are a former smoker, when did you quit_____

Do you use recreational drugs (marijuana, cocaine, crack, etc.)? Yes____ No____

Have you previously used recreational drugs? Yes____ No____

Please list any other information that you feel would be important to our providers in your medical care:

_____

Family History

Any medical illness in family: No____, if yes fill in the box below.

Illness	**Which Family Member**	**Approx Age Diagnosed**
Cancer_____		
Bleeding Disorder		
Heart Disease		
Diabetes		
Drug / Alcohol Problem		
Mental Disease		
Other_____		

I certify that the above medical history given by me in either written or verbal format is true and correct.

Printed Name_____ Date_____

Signature_____

Patient Information
Please answer all questions fully.

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1450 E. Chestnut Avenue, Suite 3-A
Vineland, NJ 08361
Phone: 856-794-8700
Fax: 856-794-2752

Patient					
Name (Last, First, MI)	Social Security	Age	Birth Date	Sex	Home Phone
Mailing Address	Mailing Address		State	Zip Code	Marital Status
Employer	Employer		State	Zip Code	Work Phone
					Cell Phone

Responsible Party					
Name (Last, First, MI)	Social Security	Age	Birth Date	Sex	Home Phone
Mailing Address	Mailing Address		State	Zip Code	Marital Status
Employer	Employer		State	Zip Code	Work Phone
					Cell Phone

Primary Provider	**Referring Provider**	**Referring Address**	**Phone**	**Fax**

Insurance Cards have been scanned into the computer system.

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I am responsible for any balances the insurance company doesn't pay to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owed to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature_____ Date_____

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Board Certified in Internal Medicine and Infectious Disease

Medical Records Release Authorization

Patient Name:_____ **DOB**_____

Home Phone:_____ **Cell:**_____ **Work:**_____

_____ I am **Not Transferring** my care but I am requesting copies of my records be forwarded to Cumberland Internal Medicine.

_____Labs
_____X-Rays
_____Doctor Notes
_____Medication List
_____Problem List
_____Hospital Records

_____ I **Am Transferring** my care but I am requesting copies of my records be forwarded to Cumberland Internal Medicine.

Cumberland Internal Medicine
1450 E Chestnut Avenue
Suite #3A
Vineland, NJ 08360

If you have Direct Messaging, please send all records to the following:

john.ahrens@cim.directbygreenway.com
vakula.atthota@cim.directbygreenway.com
badiaa.elimad@cim.directbygreenway.com
david.galetto@cim.directbygreenway.com
elizabeth.santoro@cim.directbygreenway.com

Patient Signature_____ Date_____