Cloud Surgical Solutions
Patient Profile Sheet

Name____ **Date of Birth**____/____/____
Last First MI (Nickname)

__Single __Married __Separated __Divorced __Widowed **Social Security #** ______/____/______

Address______________________________________/____
PO Box Street Address **(DO NOT LEAVE BLANK)**

City____________________________ **State**____ **Zip**________ **Home Phone** (______)______/________

Employer ____ **Work Phone** (______)______/________

Employer Address____
Street Address City State Zip

Emergency Contact_________________ **Relationship**_________ ___ **Phone** (______)______/________

Primary Care Doctor______________________________________ **Phone** (______)______/________

Insurance Information

Primary Insurance_________________________________**Insured Employer**_______________________
Insured Name__________________________ **Relationship to patient**__________________________
Insured Date of Birth_____/___/________ **Insured Social Security #** ______-____-______

Secondary Insurance______________________________ **Insured Employer**_______________________
Insured Name__________________________ **Relationship to patient**__________________________
Insured Date of Birth_____/___/________ **Insured Social Security #** ______-____-______

Responsible Party (if other than patient)

Person responsible for this account________________________ **Relationship to patient**____________
Address____ **Phone** (______)______/________

Employer____ **Phone** (______)______/________
Date of Birth_____/___/________ **Social Security #** ______-____-______

How did you learn about Dr. Cloud and our practice? (please check all that apply)

___ Insurance Provider ___ Physician ___ Relative or Friend
___ Phone Book ___ Newspaper ___ Chamber of Commerce
___ Website (www.cloudsurgicalsolutions.com) ___ Other (please specify) ____________________

If you were refered by a family member / friend, may we thank them for referring you? (the purpose of your visit will remain confidential)

Name____________________________ **Relationship to you**_______________________

revised 08/2008

Patient History Sheet

Date: ____________________________ (Please Print)

Patient:____
(Last) (First) (Middle or Maiden)

Occupation:____ **Do you do heavy lifting (30 lbs or more) at work? __Yes __No**

Marital Status: (Please circle) Single Married Divorced Widow/Widower

Your Height: ______________ **Your Weight:** ________________ **Do you wear glasses/contacts? _____Yes ____No**

Past Medical History: Mark with a check (√) if you have been diagnosed or have had any of the following:

Vascular	__Chronic Cough	__Hiatal Hernia	__Fibromyalgia	**Psychiatric**
__Peripheral Vascular Disease	__Emphysema	__Inguinal Hernia	__Joint Disease	__Depression
__Carotid Stenosis	__COPD	__Abdominal Hernia	__Other_______________	__Anxiety
__Aneurysm	__Other_________________	__Other_____________	**Skin / Breast**	__Alcoholism
__Leg Ulcers	**Cardiac**	**Genitourinary**	__Eczema	__Substance Abuse
__Varicose Veins	__High Blood Pressure	__Kidney Disease	__Psoriasis	**Endocrine**
Head / Eyes	__Low Blood Pressure	__Kidney Stone(s)	__Skin Cancer	__Diabetes
__Migraine Headaches	__High Cholesterol	__Frequent Urination	__Breast Nodules RT / LT	__Thyroid Disease
__Macular Degenerative Disease	__Irregular Heart Rate	__Urinary Incont	__Breast Cancer RT / LT	**Hematologic / Lymphatic**
__Cataracts	__Congestive Heart Failure	__Prostate conditions	__Fibrocystic Disease	__Easy Bruising
__Glaucoma	__Heart Murmur	__Other_____________	__Other	__Anemia
__Blindness	__Atrial Fib	**Gynecological**	**Neurological**	__Liver Disease
__Color Blindness	__Mitral Valve Prolapse	__Menopause	__Insomnia	__Hepatitis
Ear, Nose, Throat	__Heart Attack	__Pregnancy	__Previous stroke	__Lymphadenopathy
__Nosebleeds	**Gastrointestinal**	__Ovarian Cyst(s)	__Seizures	**Allergic / Immunologic**
__Sinus Problems	__Hemorrhoids	__Other___________	__Speech Difficulty	__Nasal Allergies
__Hearing Difficulty	__Polyps	**Musculoskeletal**	__Walking Difficulty	__AIDS / HIV positive
__Deafness	__Colon Cancer	__Muscle Disease	__Dementia	**Other**
Respiratory	__Irritable Bowel Syndrome	__Arthritis	__Alzheimer Disease	__Chemo Therapy
__Sleep Apnea	__Crohn's Disease	__Rheumatoid Arthritis	__Paralysis	__Radiation Therapy
__Asthma	__Ulcerative Colitis	__Gouty Arthritis	__Parkinson's Disease	__Allergy to Anesthesia
__Tuberculosis	__Trouble Swallowing	__Osteopenia	__Multiple Sclerosis	__Artificial Heart Valve
__Pneumonia	__Reflux	__Osteoporosis	__ADHD	__Artificial Joint(s)______
__Bronchitis	__Diverticulosis	__Back pain	__Other______________	__Stent_______________
Others not listed above:				

Mark with a check (√) if you have had any of these problems in the past month:

___Weakness or Fatigue ___Chills ___Difficulty in breathing ___Cough ___Wheezing
___Chest pain or Discomfort ___Night Sweats ___Frequent Nausea or vomiting
___Dizziness ___Weight Loss: ____pounds in the past ____months

Habits: ____Smoking, ____packs a day ____Alcohol, amount per week _______ ____Street Drugs_______________

Family History: Mark with a check (√) if any blood relative had any of the following:

___Cancer / Type: ____________________ ___Stroke ___Diabetes
___Problems with anesthesia ___Heart Disease ___High Blood Pressure

List ALL previous surgeries:____
____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits of which I am entitled. I will not hold my physician or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____________________ **Patient Signature:** ____ **(Revised 7/2/07)**

Name: ____ **Date:** __________________

ALLERGIES: (List all allergies with reactions.) **Are you allergic to:**

Foods: ___Yes ___No ____

Latex: ___Yes ___No Reaction:____

Contrast Dye: ___Yes ___No Reaction:____

Please list all MEDICATION ALLERGIES and the reaction(s) associated with that allergy.

Example: Penicillin	*Rash, breathing difficulty*

MEDICATIONS: Please list below ALL medicines that you take including prescription and over the counter medicines, such as Vitamins, etc.

MEDICINE NAME	STRENGTH (mg)	HOW OFTEN DO YOU TAKE THIS MEDICINE	REASON FOR TAKING MEDS
Example: Penicillin	*250 mg*	*2 capsules three times a day*	*Infection*

Are you required to take antibiotics before each and every visit to the Dentist because of a Heart Murmur, Mitral or Aortic Valve Prolapse (leaking heart valves), a history of Rheumatic Heart Disease and / or a joint replacement? ____Yes ____No If so, write below what you take.

____

Payment Policy & Health Authorization Information

Thank you for choosing Dr. Cloud and Cloud Surgical Solutions as your surgical provider. We are committed to providing you with quality and affordable health care. We have developed the payment policy below regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions, and sign below. A copy will be provided upon request.

1. Insurance & Proof of Insurance. All patients are required to complete our patient information forms prior to seeing a provider. We participate in most insurance plans and must obtain a copy of a current insurance card to provide proof of insurance numbers. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. 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 do not 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, Co-Insurance & Deductibles. All co-payments, co-insurance and deductibles must be paid, in full 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 is considered fraud. Please help us uphold the law by paying your co-payment at each visit. We accept cash, checks, Visa, and MasterCard. There is a $25 service charge for all returned checks.

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. Claims Submission. We will submit all claims in a timely manner, regardless of participation with insurance company, 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.

I authorize payment directly to the physicians of Cloud Surgical Solutions for any surgical/medical benefits payable to me for services provided. I understand they will file all claims with my insurance provider as a courtesy,; however it is my responsibility for payment of those charges. _______

5. Account Balance & Non-Payment. We realize it can be difficult to make large payments on balances, but you must realize we are not set up to finance large balances for long periods of time. **If your account balance is $100.00 or less, payment in full is expected at time of service. If you do not have insurance (self- pay), then payment is expected upon receipt of statement. For balances over $100.00 and up to $1,000.00 we require that the account be paid in full within six (6) months from the date of service. For balances over $1,000.00 we require that the account be paid in full within twelve (12) months from the date of service.** If payment arrangements are not maintained and balances are not paid in a timely manner we will report this to credit agencies, which can affect your credit rating. We strive to avoid this whenever possible so, communication with our billing agency, CME Billing 828-438-8577 and/or with our Practice Manager, Elaine Butler, 828-437-0847 is very important. Any difficulty in maintaining payments should always be discussed promptly.

6. Disability & Insurance Forms. We charge $10.00 per form for completion. Payment is due before forms are returned to patient.

I authorize the relase of my personal health information to complete any disability & insurance forms. ______

7. Privacy Protection.

I have been provided with a written or oral explanantion of the Health Inforamtion Policies followed by Cloud Surgical Solutions, P.A., which are in accordance with federal HIPPA regulations. An additional copy is available to me upon request. _______

In an effort to protect my privacy:
I authorize the following person(s) to receive information regarding my care. _______

Name ______________________________ *Relationship* ________________________
Name ______________________________ *Relationship* ________________________
Name ______________________________ *Relationship* ________________________

I <u>do not</u> authorize anyone other than myself to receive inforamtion regarding my health care, treatment, test results & etc. _______

Thank you for understanding our payment policy & health authorization information. Please let us know if you have any question or concerns. I have read and understand the payment policy and agree to abide by its guidelines: ________________________________ _____________

Signature of patient or responsible party *Date*

8/08cpl