2015
CLOUD CARE MEDICINE
YOUR HOMETOWN DOCTOR

PATIENT'S PERSONAL INFORMATION

General

Last Name:_____ First:_____ M.I.:_____
Home Address: _____ Apt.: _____ City: _____
State: _____ Zip: _____
Home Telephone: (____)_____Cell Phone: (____)_____
Date of Birth: _____/_____/_____ Age: _____ Sex: _____
Social Security Number: _____-_____-_____

Driver's License Number: _____ Email Address: _____
Marital Status (Circle): Single Married Domestic Partner Divorced/Widowed

Primary Insurance

Company Name: _____ Group Number: _____
Policy Number_____ Address: _____ City: _____
State: _____ Zip: _____
Insured's Date of Birth: _____/_____/_____ Insured's Name: _____
Insured's Social Security Number: _____-_____-_____ Relationship to Insured: _____

Secondary Insurance

Name: _____ Group Number: _____
Policy Number_____ Address: _____ City: _____
State: _____ Zip: _____ Insured's Date of Birth: _____/_____/_____
Insured's Name: _____
Insured's Social Security Number: _____-_____-_____Relationship to Insured: _____

Emergency Contact

Name: _____ Relationship:_____ Phone:
(_____)_____

Pharmacy:_____
Address**:** _____
Phone: **(**_____**)**_____**-**_____

Authorization I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.
Signature:_____ Date:_____

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Informed Patient Consent

HIPAA Compliance Patient Consent Form

How did you hear about us? Please check one:

___Friend/Relative ___Online search ___Billboard ___Driving/walking by

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

I am initiating contact with the understanding that the medical encounter will be conducted through the use of:

• Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

• The practice reserves the right to change the privacy policy as allowed by law.

• The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

• The practice may condition receipt of treatment upon execution of this consent.

• The practice has the right to revoke this consent in writing at any time.

Telemedicine

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records

· Medical images

· Live two-way audio and video

· Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

-Potentially reducing the spread of infectious diseases by eliminating direct contact between patient and provider.

· More efficient medical evaluation and management.

· Obtaining expertise of a distant specialist.

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

· In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

· In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

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I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

For Immigration exams only:

____(Initial) I agree that, once completed, Cloud Care Medicine is not responsible for any damage, loss, or theft of any documentation related to my immigration case. Replacement documents can be issued by appointment, at full price.

____(Initial) I agree that all fees associated with immigration medical exams, bloodwork, and documentation are non-refundable.

For patients with out-of-network Insurance only:

____(Initial) I understand that if Cloud Care Medicine and its providers are not considered in-network with my health insurance provider, obtaining referrals or orders for specialist providers, medical equipment, and certain medications may not be possible.

I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize Cloud Care LLC to use telemedicine in the course of my diagnosis and treatment.

All patients:

I authorize Cloud Care LLC and its healthcare providers, as my healthcare provider, to perform medical services and procedures as designated by clinicians including but not limited to physical examinations, diagnostic testing, medication orders and administration, chronic care management, remote patient monitoring, and specialist referrals.

Patient (Print): _____ Date of Birth:_____

Signature: _____ Date: _____

Power of Attorney:_____

Signature:_____Date:_____

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CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Cloud Care Medicine is to provide you with convenient, accessible, high quality medical care. To assure convenience and accessibility to all our patients, it is important that patients arrive in a timely manner for all scheduled appointments or cancel the appointment at least 24 hours in advance. This policy allows us to make better use of our available appointments for those patients in need of medical care. We appreciate your support and understanding.

Cancellation of an Appointment - You may cancel your scheduled appointment by calling our office during regular business hours. Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen by a provider.

Missed Appointment Policy - A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment at least 24 hours in advance, we will record this in the medical record as a "missed appointment". Each time you miss your appointment, you will be notified by telephone and you will be asked to re-schedule.

Appointment Confirmation Policy - Because have many patients on a waiting list for appointment times it is very important that you confirm your appointment. We will contact you approximately 24-48 hours before your appointment to confirm. If we cannot reach you or you do not return our communication to confirm your appointment at least 24 hours before your scheduled time, you may be cancelled.

Fees for Appointments – Financial Agreement Effective April 28, 2021, Cloud Care Medicine will begin to charge patients when they do not present for scheduled appointments. Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for a missed appointment. This fee will not be submitted to the health plan; it will be charged to the patient. The missed appointment fee structure is **$35** for all types of appointments. This fee must be paid prior to scheduling a new appointment. **Fee is subject to change*

CANCELLATION & MISSED APPOINTMENT POLICY - I pre-authorize Cloud Care Medicine to use the payment information (debit card and / or credit card) on file to charge for the applicable fees. If there is no payment information on file, I understand that I will be billed for the applicable fee. I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments.

Patient Name:_____ Sign:_____

Date:_____Date of Birth:_____

Guardian/POA (If applicable):_____Sign:_____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. I authorize the following using or disclosing party: _____ to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other:_____

The above party may disclose this health information to the following recipient: Name (or title) and organization: **CLOUD CARE MEDICINE** Address **1222 10TH St** City **ST CLOUD** State **FL** Zip **34769** Phone **407-593-0323** Fax **407-593-0324**

The purpose of this authorization is (check all that apply): ☐ - At my request ☐ - Other:

_____

II. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Please fax records to: 407-593-0324 Email: info@cloudcaremedicine.com

CLOUD CARE MEDICINE
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PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

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Patient Health Questionnaire - 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
		⑤	

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⑤ ⑤ ⑤

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____