

Manuel H. Hernandez, MD, PA

Dermatology & Mohs Skin Cancer Surgery

4235 Kings Hwy Ste 101 • Port Charlotte, FL 33980

(941) 764-7773 • Fax (941) 764-7681

Please complete the following forms and bring them to your appointment with Dr. Hernandez.

We will also need you to bring the following:

Insurance cards

Photo identification

List of medicines

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Female Male

Local Mailing Address _____

Seasonal Mailing Address _____

Marital Status: Single Married Widowed Divorced • Social Security #. _____

Emergency Contact _____ Phone: _____

Spouse/Partner Name _____ Phone: _____

Patient Phone _____ Patient Cell phone _____ Email _____

Employment Status: Retired Full Time Part Time Unemployed

Employer _____ Occupation _____ Phone _____

Preferred Pharmacy _____ Phone: _____

Pharmacy Address / Intersection _____

Primary Care Physician _____ Phone _____

Referred by: Dr. _____ Newspaper Ad Internet Friend / Another Patient

Insurance Policies: (Fill Out Form and Provide Cards to Scan)

Primary Medical Insurance _____ Policy Num. _____ Group Num. _____

Insured's Name _____ Relationship _____ Date of Birth _____

Secondary Medical Insurance _____ Policy Num. _____ Group Num. _____

Insured's Name _____ Relationship _____ Date of Birth _____

I certify that the information I provided is correct. *I am responsible for advising the practice of any changes in my insurance, address or telephone number*

Patient _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

Relationship to Patient: Parent Guardian Power of Attorney

FINANCIAL AGREEMENT

This financial agreement should answer questions regarding your responsibility for services rendered. Your clear understanding of our financial policy is important to us. Please ask us if you have any questions.

Your insurance is a contract between your insurer and you. You are responsible for knowing and understanding the terms of your policy, including deductible, copay and coinsurance. You are also responsible for all costs not covered by your health insurance policy.

Assignment of Benefits

I hereby authorize direct payment, on my behalf, of surgical / medical benefits to Manuel H. Hernandez, M.D., P.A., for services rendered by Dr. Manuel Hernandez in person or under his supervision.

Original/Traditional Medicare

Manuel H. Hernandez, M.D., P.A. is an Original/Traditional Medicare provider and will submit your health insurance claim to Medicare. You will be responsible for paying any copay, co-insurance and/or deductible at time of service, if not covered by your secondary/supplemental insurance policy.

Medicare Advantage Plans

Manuel H. Hernandez, M.D., P.A. will file **most PPO Medicare Advantage Plan** claims. These claims will be filed as **out of network**. Your deductible, copay, and coinsurance may be higher for out of network providers, and are due at time of service.

However, our practice **will not file** claims to **Health Partners PPO, Priority Health PPO, or any HMO, PFFS, or SNP Medicare Advantage Plans. Patients with these plans are considered self-pay and responsible for payment in full at time of service.**

Secondary/Supplemental Insurance Plans

As a courtesy, we will bill your secondary insurance once only. If no payment is received in a timely manner, you will be responsible for payment and for submitting to your secondary insurance policy for reimbursement. It is your responsibility to know if Manuel H. Hernandez, M.D., P.A. is an out of network provider with your secondary insurance plan, and if so, your deductible, copay and coinsurance may be higher, and due at time of service. You are also responsible for charges approved by Medicare if your secondary insurance does not pay.

Missed Appointments

Kindly notify us at least **24 hours** prior if you are unable to keep your scheduled appointment or a **\$50.00 fee will be charged for missed appointments**. Missed appointments represent a cost to the practice and to other patients that could have used the time slot assigned to you.

Pathology/Laboratory Fees

Pathology or laboratory services may be sent out to an outside lab facility for testing. You and/or your insurance company will be billed directly from that lab for those services. It is your responsibility to pay them directly.

Medical Records

Medical Records are subject to a processing fee determined by state law.

Method of Payment

Payment, in cash or check, is required at time of service.

Returned Check Fees

Bank returned checks will be subject to a non-sufficient fund fee of \$25.00, in addition to the amount of the check returned uncashed.

Collection Fees

Statements are mailed monthly to patients with outstanding balances. Payment is due upon receipt. Balances over 90 days will be sent to our collection agency and may be subject to other collection activity. Each person signing below agrees to be responsible for prompt payment on the patient's account and for all reasonable costs of collection, including any attorney fees. Each of the undersigned further agrees that (i) personal information may be forwarded to a collection agency in connection with the collection of any delinquent balance on the patient's account; and (ii) accurate information regarding any delinquency on the patient's account may be reported to credit bureaus and credit reporting agencies.

I hereby attest that I have read, understand, and consent to the terms contained in this financial agreement.

Patient _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

Relationship to Patient: Parent Guardian Power of Attorney

Manuel H. Hernandez, MD, PA

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Receipt of Notice of Privacy Practices & Patient Authorization for Practice to Release Protected Health Information

Your signature below acknowledges having received or given the opportunity to receive a copy of the Notice of Privacy Practices for Manuel H. Hernandez, MD, PA. A complete copy of the Notice of Privacy Practices for Manuel H. Hernandez, M.D., P.A. is available to you at our web site, www.hernandezskincancer.com, or upon request at the office.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

I authorize the release of any medical or incidental information, on request, that may be necessary for my medical care, and as necessary to process insurance claims, and prescriptions. Moreover, I authorize direct payment, on my behalf, of surgical / medical benefits to Manuel H. Hernandez, M.D., P.A., for services rendered by Dr. Manuel Hernandez in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Do you give our office permission to disclose, discuss and speak to another individual? Yes No

If yes, please provide names, phone number, and relation to you:

Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization.

Patient _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

Relationship to Patient: Parent Guardian Power of Attorney

REVIEW OF SYSTEMS

Patient _____ DOB _____

Do you have any of the following? (Circle Yes or No)

Allergy to lidocaine or local anesthetics	Yes	No
Allergy to latex	Yes	No
Allergy to tape or band-aids	Yes	No
Allergy to topical antibiotic ointments	Yes	No
HIV / AIDS	Yes	No
Organ transplant	Yes	No
Immunosuppressives, methotrexate or biologics	Yes	No
Rapid heartbeat with epinephrine	Yes	No
Artificial heart valve	Yes	No
Premedication prior to procedures	Yes	No
Defibrillator	Yes	No
Pacemaker	Yes	No
Blood clots / pulmonary embolus	Yes	No
Stroke / TIA	Yes	No
Chest pain	Yes	No
Artificial joints within past 12 months	Yes	No
Blood thinners	Yes	No
Problems with bleeding	Yes	No
MRSA	Yes	No
Hepatitis C	Yes	No
Problems with healing	Yes	No
Problems with scarring (hypertrophic or keloid)	Yes	No
Rash	Yes	No
New or changing lesion	Yes	No
Herpes virus, cold sores, fever blisters on the lips or face	Yes	No
Shortness of breath	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Glaucoma	Yes	No

Patient _____ DOB _____

CURRENT MEDICAL CONDITIONS (*Circle all that applies*)

None	HIV - Human immunodeficiency virus infection
Anxiety disorder	High Cholesterol - Hypercholesterolemia
Arthritis	Hyperthyroidism
Asthma	Hypothyroidism
Atrial fibrillation	Hepatitis – Inflammatory disease of liver
Stroke – Cerebrovascular accident	Leukemia
COPD - Chronic obstructive lung disease	Malignant Lymphoma
Coronary heart disease (arteriosclerosis)	Breast cancer
Depression	Cancer of colon
Diabetes mellitus	CA - Lung cancer
End stage renal disease	Cancer of prostate
Epilepsy	Radiation therapy treatment
H/O hypertension	Bone marrow transplant
H/O pulmonary embolus	Other: _____
H/O deep vein thrombosis	_____

Patient _____ DOB _____

PAST SURGERIES (*Circle all that applies*)

<p>None</p>	<p>Mechanical heart valve replacement</p>
<p>Coronary artery bypass graft</p>	<p>Prostatectomy (Prostate Removal)</p>
<p>Entire transplanted kidney</p>	<p>Splenectomy (Spleen Removal)</p>
<p>Excision of basal cell carcinoma</p>	<p>Surgical biopsy of skin</p>
<p>Excision of melanoma</p>	<p>Total nephrectomy (Kidney Removal)</p>
<p>Excision of squamous cell carcinoma</p>	<p>Total replacement of left hip</p>
<p>H/O bilateral mastectomy (Removal of Both Breasts)</p>	<p>Total replacement of left knee</p>
<p>H/O colectomy (Colon Surgery)</p>	<p>Total replacement of right hip</p>
<p>H/O percutaneous transluminal coronary angioplasty (Heart Stents)</p>	<p>Total replacement of right knee</p>
<p>H/O tissue graft heart valve replacement</p>	<p>Transplantation of heart</p>
<p>Hysterectomy (Removal of Uterus)</p>	<p>Transplantation of liver</p>
<p>Mastectomy of left breast (Left Breast Removal)</p>	<p>Other: _____</p>
<p>Mastectomy of right breast (Right Breast Removal)</p>	<p>_____</p>

SKIN DISEASE HISTORY (*Circle all that applies*)

None	Photo dynamic therapy of skin / blue light
Acne	Psoriasis
Actinic keratosis	Rosacea
Basal cell carcinoma	Squamous cell carcinoma
Dysplastic nevus (Atypical moles)	Sunburn of second degree
Eczema	Xerosis cutis / dry skin
Fluorouracil / Efudex	Other _____
Malignant Melanoma	_____

Do you wear sun screen? Yes No What SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If YES, which family member? (*Circle*) Parent Sibling Child Other _____

Are you allergic to any medications? Yes No

If yes, please list medications and provide type of reaction: _____

Smoking Status (*Circle*): Never **Current** Former

Do you have a living will? Yes No

Patient Name _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

Relationship to Patient: Parent Guardian Power of Attorney