MANUEL H. HERNANDEZ, M.D., P.A.

Diplomate, American Board of Dermatology

Mohs Micrographic Surgery for Skin Cancer
Dermatology ~ Dermatologic Surgery ~ Skin Laser Surgery

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
- Medical records from prior Doctor. Please have them faxed at (941)764-7681 before your visit.

If you have any questions regarding this information or your appointment, please call our office at (941)764-7773.

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Dermatology / Mohs Skin Cancer Surgery / Dermatologic Surgery

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Num. _____ Date of Birth _____ Age _____ □Female □Male

Local **Mailing Address** Street _____

City _____ State ____ Zip Code_____ Phone _____

Summer /Permanent **Mailing Address** Street: _____

City _____ State ____ Zip Code_____ Phone _____

Marital Status: □Single □Married □Widowed □Divorced

Name of Partner/Spouse _____Name of Primary / Family Physician_____

Name of Person to Contact in Case of Emergency _____Phone: _____

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

Employment Status: □Retired □Full Time □Part Time □Unemployed

Employer _____ Occupation _____Phone _____

Street_____ City_____ State _____Zip Code_____

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

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

Release of Information and Assignment of Benefits

I hereby authorize Manuel H. Hernandez, M.D., P.A. to release any medical or incidental information, on request, that may be necessary for my medical care.

I authorize Manuel H. Hernandez, M.D., P.A. to release all records to insurance companies, including Medicare, or their agencies, for the purpose of payment of medical claims.

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. I understand that I am financially responsible for any balance not covered by my insurance.

Patient_____ Signature _____ Date_____

Parent/Guardian _____ Signature _____ Date_____

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.

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 your health insurance claim to your ***PPO Medicare Advantage Plan***, as a ***non-participating / out of network provider***. Your deductible, copay, and coinsurance may be higher when choosing an out of network provider, and it is due at time of service.

The practice will ***not*** file your insurance claim to any ***HMO, PFFS, or SNP Medicare Advantage Plan.*** You will have to pay in full, at time of service, for all charges if your Medicare Advantage Plan is not a PPO plan.

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 appointment or the practice reserves the right to assess a cancellation fee. 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_____

Parent/Guardian _____ Signature_____

Relationship to Patient: ☐Parent ☐Guardian ☐Power of Attorney

Receipt of Notice of Privacy Practices &

Patient Authorization for Practice to Release Protected Health Information

My signature below acknowledges receipt of the Notice of Privacy Practices for Manuel H. Hernandez, M.D, P.A.

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, and 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).

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_____
Parent/Guardian _____ Signature_____
Relationship to Patient: □Parent □Guardian □Power of Attorney

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FELLOWSHIP TRAINED, MOHS SURGERY AND SKIN LASER SURGERY

PATIENT QUESTIONNAIRE

INSTRUCTIONS: PLEASE FILL IN BOTH SIDES OF FORM (FRONT AND BACK)

Name:_____Date:_____

CURRENT SKIN PROBLEM

What is your skin complaint?_____
Duration:_____
What prior treatments?_____
What makes it worse?_____

PAST MEDICAL HISTORY

What medical problems are you being treated for?_____
_____
_____
What surgeries have you had?_____
_____

Have you had any of the following? (Circle appropriate answer)
Blood transfusions…….No Yes
Hepatitis…….No Yes
Artificial heart valves ……No Yes
Vascular/vein grafts or stents ……No Yes
Artificial joints ……..No Yes
AIDS or HIV…….…….No Yes

HAVE YOU EVER HAD ANY SKIN CANCER? (Circle appropriate answer)
No
Yes. Basal cell carcinoma Where?_____
Squamous cell carcinoma Where?_____
Melanoma Where?_____
Cannot remember type Where?_____
Other _____

MEDICATIONS

List your medicines:_____
_____

Do you take the following medications: (Circle the appropriate medicine)
Aspirin, Motrin, Advil, Aleve, Ibuprofen, coumadin, Celebrex, arthritis medications, Vitamin E, Plavix, other blood thinners _____

What medicines are you allergic to? _____
_____

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PATIENT QUESTIONNAIRE (CONTINUED)

SOCIAL HISTORY (Circle appropriate answer)
Where are you from originally? _____
Do you smoke cigarettes? No / **Yes** How many packs per day?_____ How many years?_____
Do you drink alcohol? No / **Yes** Approximately how much per week?_____

FAMILY MEDICAL HISTORY
Did anyone in your immediate family (**parents or siblings only**) have any of the following?
Heart attacks? No / **Yes** _____
High blood pressure? No / **Yes** _____
Diabetes? No / **Yes** _____
Melanoma (parents, grandparents or siblings)? No / **Yes** _____
Other types of skin cancer? No / **Yes** _____
Is there any condition that runs in your family that we should know about?
No / **Yes** _____

SYMPTOMS REVIEW
Have you recently experienced any of the following symptoms? (Circle appropriate answer)

Constitutional: Fever / Weight loss / Tiredness./.Other:_____
Eyes: Cataracts / Glaucoma / Poor vision Other:_____
Ears, nose throat: Difficulty swallowing / Bleeding nose / Poor hearing / Other:_____
Cardiovascular: Chest pains / Pain on the legs / Swollen legs /Other:_____
Respiratory: Difficulty breathing / Asthma / Emphysema / Other:_____
Endocrine: Thyroid disease / Diabetes / Other_____
Cancer: Lung cancer / Colon cancer / Prostate cancer / Breast cancer / Other:_____
Blood system: Anemia / Lymphoma / Leukemia / Other:_____
Immune system: Lupus / Transplanted organs / Chemotherapy / Other:_____
Gastrointestinal: hepatitis A / B / C / Diarrhea / Nausea / Vomiting / Other:_____
Musculoskeletal: Arthritis / Joint pain / Joint replacements / Other:_____
Neurologic: Stroke / Seizures / Damaged nerves / Other:_____
Psychiatric: Depression / Schizophrenia / Anxiety / Other:_____

None of the above

The above information was reviewed with the patient.

Patient initials:_____Date:_____

Nurse/physician initials:_____Date:_____

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