

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

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ADDENDUM TO FINANCIAL AGREEMENT #1

Manuel H. Hernandez, M.D., P.A. will no longer file your insurance claim to the following PPO Medicare Advantage Plans:

-Health Partners

-Priority Health

Payment is due in full, at time of service, for all charges if your insurance carrier is named in the above list.

I hereby attest to have read and understood this addendum.

Patient/Guardian Signature

Date

**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

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

Diplomate, American Board of Dermatology
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 valvesNo Yes

Vascular/vein grafts or stentsNo Yes

Artificial jointsNo 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: _____