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 _____

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

Date of Birth _____ Age _____ City / Country of Birth _____

☐Female ☐Male • Primary Language: ☐English ☐Spanish ☐Other

Emergency Contact _____Phone: _____

Spouse/Partner Name_____

Patient Phone_____ Patient Cell phone _____ Email _____

***Local* Mailing Address** _____

***Seasonal* Mailing Address** _____

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

Employer _____ Occupation _____Phone _____

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 _____

Primary Care Physician_____ Phone _____

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

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_____

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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 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_____ Date_____

Parent/Guardian _____ Signature_____ Date_____

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 _____ Signature_____ Date_____

Parent/Guardian _____ Signature_____ Date_____

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

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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_____

Preferred Pharmacy_____ Phone_____

Address / Intersection:

CURRENT MEDICAL CONDITIONS (*Circle all that applies*)

None	Epilepsy
Anxiety disorder	H/O deep vein thrombosis
Arthritis	H/O pulmonary embolus
Asthma	Hepatitis
Atrial fibrillation	High Cholesterol
BMT - Bone marrow transplant	H/O hypertension
Breast cancer	HIV
CA - Lung cancer	Hyperthyroidism
COPD - Chronic obstructive lung disease	Hypothyroidism
Cancer of colon	Leukemia
Cancer of prostate	Lymphoma
Coronary heart disease	Radiation therapy treatment
Depression	Stroke
Diabetes mellitus	Other: _____
End stage renal disease	_____

Patient _____DOB _____

PAST SURGERIES (*Circle all that applies*)

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

Are you allergic to any medications? Yes No
<u>If yes</u>, please list medications and provide type of reaction: _____
_____

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_____

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

Do you have a health care proxy? Yes No Designee's Name _____Phone_____

Do you have a living will? Yes No

Wishes on advanced care recommendations: *(Please circle below)*

Do Not Intubate *Do Not Resuscitate* *Full Cardiopulmonary Resuscitation*

Patient Name _____Signature _____ Date_____