Welcome to Our Office

Hector N. Hernandez, M.D., P.A.
21297 Olean Boulevard • Port Charlotte, FL 33952
Tel. 764-0660

TODAY'S DATE _____

In order to assist you, we will need the following information. Please print.

PATIENT INFORMATION

Last Name		**First Name**	**Middle Initial**
Social Security No.	**Date of Birth**	**Age**	❒ **Female** ❒ **Male**
Local Address			
City	**State**	**Zip Code**	**Phone**
Permanent /Summer Address			
City	**State**	**Zip Code**	**Phone**

Marital Status: ❒ **Single** ❒ **Married** ❒ **Widowed** ❒ **Divorced**

Employment Status: ❒ **Retired** ❒ **Employed** ❒ **Not Employed**

Employer	**Occupation**
Street	

City	**State**	**Zip Code**	**Phone**

Referred By: ❒ **Dr.**_____ ❒ **Newspaper ad** ❒ **Yellow pages** ❒ **Friend/Family** ❒ **Other (*please specify*)**_____

INFORMATION ON PARENTS/GUARDIAN *(if applicable)*

(Please check one) ❒ Mother ❒ Father ❒ Guardian	Name:		
Home Address:	Soc. Sec. No.		
City	State	Zip Code	Phone
Employer:	Occupation		
Work Address:			
City	State	Zip Code	Phone

Does this parent or guardian have legal custody of the patient? ❒ YES ❒ NO

If not, please provide the name, address and phone number of the person who does have legal custody of the patient

INSURANCE

Do you have medical insurance? ❒ YES ❒ NO If YES, please complete the following:

PRIMARY INSURER:
❒ Medicare ❒ CHAMPUS ❒ Railroad Medicare
❒ Blue Cross (Health Options/HMO) ❒ Blue Cross (non-HMO)
❒ Other *(please specify)* _____

SECONDARY INSURER:
❒ Aetna U.S. Healthcare ❒ AARP ❒ Blue Cross
❒ United Healthcare ❒ Medicare ❒ Medicaid
❒ Other *(please specify)* _____

Please provide the receptionist with ALL of your insurance cards. We will make copies for your file in order to facilitate the filing of claims.

ASSIGNMENT AND RELEASE

Assignment of Insurance Benefits: I hereby authorize direct payment of surgical/medical benefits to Dr. Hector N. Hernandez for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance in a timely manner. I authorize the use of this signature on all insurance submissions. I agree and acknowledge that my signature on this document authorizes Dr. Hernandez to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each such claim to be submitted, and that I will be bound by my signature below as though I had personally signed each claim.

Authorization to Release Information: I hereby authorize Dr. Hector N. Hernandez to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I expressly authorize release of medical information to my primary or referring physician upon his/her request and/or as deemed necessary by Dr. Hernandez.

Blood Testing: If anyone is exposed to my blood or bodily fluids as a result of providing or assisting with my care, I consent to my blood being drawn and tested for communicable diseases, including but not limited to HIV (AIDS virus).

Medicare • Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I further specifically authorize release to the Health Care Financing Administration and its agents any information needed or requested to make benefit determinations. I request that payment of authorized benefits be made on my behalf directly to Dr. Hernandez.

A photocopy or fax copy of this Assignment and Release shall be valid as the original.

_____ _____
Patient's signature Date

I agree to all of the foregoing, agree to be financially responsible for all charges, and hereby certify that I am legally authorized to execute this Assignment and Release on behalf of, and make medical decisions for, the above-named patient.

_____ _____
Parent/Guardian's signature Date

Hector N. Hernandez, M.D., P.A.
(941)764-0660 ■ Fax (941)764-0664

MEDICAL BACKGROUND INFORMATION

_____ _____ _____
Patient Name Date of Birth Date

1. Allergies / Sensitivities to Medications: __ None __ Yes. Please list:_____

_____

_____

2. Personal Illnesses / Conditions: (check off answer, or fill in when necessary) **__ No known illnesses**

__ High blood pressure __ Diabetes __ Heart attack __ Stroke __ Angina / coronary artery disease
__ Abnormal heart rhythm __ Daily use of aspirin or blood thinners __ Cardiac pacemaker
__ Heart murmur or mitral valve prolapse __ Prosthesis or artificial body parts (heart / vascular / joint)
__ Asthma / COPD / Emphysema __ Cancer - if yes, what type of cancer? _____
Other illnesses: _____
_____

3. Past Surgeries: (check off answer, or fill in when necessary) **__ No previous surgery**

__ Tonsils / Adenoids __ Skin cancer surgery __ Septoplasty / nose surgery __ Ear surgery_____
Other surgeries: _____
_____

4. Family Medical History: (circle answer)

Bleeding problems (Y / N) **Reactions or allergy to anesthesia** (Y / N) **Cancer** (Y / N)
Hearing loss (Y / N) **Heart disease** (Y / N)
Other:_____
Mother (alive / deceased) If deceased, what reason?_____
Father (alive / deceased) If deceased, what reason? _____

5. Social historv / Personal habits: (circle answer or fill in when necessary)

Marital status: __ Single __ Married __ Widowed __ Divorced
Tobacco (Yes / No / Quit) If answered Yes or Quit, how many packs per day? _____ For how long?_____
If you quit, how long ago? _____
Alcohol (Y / N) If yes, how much? _____
Recreational Drugs (Y / N) If yes, what kind? _____
Coffee / Tea (Y / N)

_____ _____ _____
Nurse / assistant signature Patient signature Physician signature

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MEDICAL BACKGROUND INFORMATION

_____ _____ _____
Patient Name Date of Birth Date

6. Review of Systems: (check off symptom / condition if positive, otherwise check off "all negative")

General: __ all negative __ Fever __ Fatigue __ Weight loss __ Weight gain

Ears: __ all negative __ Drainage __ Pain __ Pressure __ Hearing loss __ Ear Itch
__ Frequent infections __ Noise in ears or head __ Vertigo (room or head spinning sensation)
__ Dizziness __ Imbalance

Nose: __ all negative __ Runny nose __ Sneezing __ Nose Itch __ Post nasal drip __ Obstruction
__ Congestion __ Nosebleeds __ Sinus headaches

Throat: __ all negative __ Sore throat __ Frequent infections __ Hoarseness __ Difficulty swallowing
__ Sensation of lump or foreign body in throat __ Phlegm buildup __ Painful to swallow

GI: __ all negative __ Heartburn __ Stomach ulcers __ Belching

Respiratory: __ all negative __ Snoring __ Shortness of breath __ Cough __ Wheezing

Lymphatic: __ all negative __ Enlarged neck glands __ Easy bruising __ Bleeding or clotting problems

Urinary: __ all negative __ Enlarged prostate __ Difficulty voiding

Cardiovascular: __ all negative __ Chest pain __ Angina __ Heart Palpitations

Skeletal: __ all negative __ Neck pain __ Neck stiffness __ Hip / Knee arthritis __ Back / spine arthritis

Eyes: __ all negative __ Recent loss of vision __ Double vision __ Itchy eyes __ Tearing

Neurologic: __ all negative __ Numbness of feet / legs __ Arm Numbness __ Headaches __ Migraines

Skin: __ all negative __ Skin cancer __ Abnormal face / neck skin growth

Allergic: __ all negative __ Environmental allergies: _____

Other: _____

_____ _____ _____
Nurse / assistant signature Patient signature Physician signature

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(941)764-0660 ■ Fax (941)764-0664

MEDICAL BACKGROUND INFORMATION

Patient Name	Date of Birth	Date

7. Medications: (Write in name, dose and frequency.) If you brought in a printed, up to date list, give the list to our staff for photocopying and check off here: **__ See separate list.**

Medication name	Dosage	Frequency

Nurse / assistant signature	Patient signature	Physician signature

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(941)764-0660 ■ Fax (941)764-0664

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. WHAT THIS IS

This Notice describes the privacy practices of Hector N. Hernandez, M.D., P.A. ("the Practice"). We are required by law to maintain the privacy of medical and health information about you ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

II. DISCLOSURE OF PHI

When we use or disclose PHI, we are required to abide by the terms of this Notice (or any other notice in effect at the time of the use or disclosure). In certain situations, described below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for treatment, payment purposes and our own health care operations, and we may use and disclose PHI, but not your "Highly Confidential Information" (defined below), in order to treat you, obtain Payment for services provided to you and conduct our "Health Care Operations". We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive Payment for services they render to you, or conduct certain Health Care Operations.

We may also make the following disclosures:

Disclosure to Relatives. Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Privacy Officer. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose PHI in order to notify such persons of your location, general condition or death.

Special Consent. Confidential HIV related information, treatment for substance abuse or sexually transmitted diseases information will never be used or disclosed to any person without your specific written consent, except as may be permitted by law.

Public Health Activities: Health or Safety. We may disclose PHI for public health activities and to a health oversight agency. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the publics health or safety.

Judicial and Administrative Proceedings; Law Enforcement; Required by Law. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. We may disclose PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. We may disclose PHI to units of the government. We may disclose PHI as otherwise required or permitted by law.

Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain Highly Confidential Information about you ("Highly Confidential Information'). In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

III. USE AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we only may use or disclose PHI when you give us your authorization on our authorization form.

IV. YOUR INDIVIDUAL RIGHTS

For Further Information: Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may

contact our Privacy Officer. You may also file written complaints with the Director Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

Additional Information. You may request restrictions on our use and disclosure of PHI (1) for Treatment, Payment and Health Care Operations, (2) to individuals involved with your care or with Payment related to your care, or (3) to notify individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Officer and submit the completed form to the Privacy Officer. We will send you a written response. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations, You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Privacy Officer and submit the completed form to the Privacy Officer. You may revoke any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Officer identified below. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Officer and submit the completed form to the Privacy Officer. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

V. EFFECTIVE DATE AND DURATION OF THIS NOTICE

1. **Effective Date.** This Notice is effective on April 14,2003.

2. **Right to Change Terms of this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Practice. You may also obtain any revised notice by contacting the Privacy Officer.

VI. PRIVACY OFFICER

You may contact the Privacy Officer at:

Hector N. Hernandez, M.D., P.A.
P.O. Box 512284
Punta Gorda, FL 33951-2284
1-941-764-0660

Hector N. Hernandez, M.D., P.A.
(941)764-0660 ■ Fax (941)764-0664

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Hector N. Hernandez, M.D., P.A. I have read and understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient (or Personal Representative)