Dennis L. Fernandez, M.D., P.C.

Patient Information

Patient's Name____
Last Name First Name Middle Name

Address____ City____________________

State______ Zip_________ Home Phone (______)______________ Cell Phone (______)____________

Sex_________ Date of Birth ______________________ SSN__________________________
MM/DD/YY

Patient's Employer______________________ Occupation__________________ Work Phone (______)________

Emergency Contact

Contact's Name__________________________ Relationship_____________________ Phone (______)________

Primary Care Physician

Name ____ Phone number __________________________

Insurance Information

Primary Insurance____________________________Group #_______________Contract # ____________________

Name of Insured____ Relationship to Patient_______________________

Sex___ Birth Date__________ Address____

Secondary Insurance__________________________Group #_______________Contract # ____________________

Name of Insured____ Relationship to Patient_______________________

Sex___ Birth Date__________ Address____

Third Insurance______________________________Group #_______________ Contract # ___________________

Name of Insured____ Relationship to Patient_______________________

Sex___ Birth Date__________ Address____

Authorization to Release Information, Assignment of Benefits, and Acceptance of Privacy Practices

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dennis L. Fernandez, M.D., P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request the payment from my insurance company be made directly to Dennis L. Fernandez, M.D., P.C. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

I will be responsible for payment of any and all services rendered to the patient listed above by Dennis L. Fernandez, M.D., P.C. and the costs of collection. I agree to pay up to 33.5% of the unpaid balance for collection fees, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that I am responsible for reasonable collection costs and in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

Patient's Signature____ Date____________________________

If not signed by patient, name and relationship to patient ____

Patient update signature____ Date_________________________

Patient update signature____ Date_________________________

Patient Name____ **Date of Birth** ________________________

Food and Drug Allergies	Reaction Experienced
Are you allergic to Latex? Yes No	
Are you allergic to Penicillin? Yes No	
Are you allergic to Keflex? Yes No	

List any additional allergies on the back of this page.

List all medications and supplements you are taking including Dosage and Frequency

Prescribed Medication/Over-the-Counter Meds Supplements: Name	Dosage	Frequency

List additional medications, dosages, and frequencies on the back of this page.

*****It is very important that we know if you are taking any of the following medications and supplements. If you are, be sure to WRITE THEM in the list above AND provide the dosage and frequency:**
Blood thinners aspirin Fish Oil Krill Oil Vitamin E diuretic (fluid pill) garlic (in pill form) over the counter herbs or vitamins

☐ I am not taking any of the above-mentioned items.

Family Health History: (please circle health problems of family) ☐**Check box if no known family health history**

Father: High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_________) Other_______________

Mother: High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_________) Other_____________

Brother(s): High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_________) Other___________

Sister(s): High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_________) Other ____________

Grandparents____

Social History: (please circle your responses)

Do you smoke? Never smoked No longer a smoker Current smoker _____ packs per day Current E-cigarette user

Occupation: Employed Retired Unemployed Disabled

Marital Status: Married Divorced Separated Single Widowed Widower

Do you drink alcohol? YES NO If yes, how much? ____ Seldom OR ____ drinks per week

Do you use illicit drugs? YES NO If yes, what drugs? ____

Patient's Signature____ Date_______________________

Dennis L. Fernandez, M.D., P.C.

Patient Name____ **Date of Birth** _______________________

Past Medical History: (circle all that you are currently treated for) ☐**Check box if past medical history is unremarkable**

High Blood Pressure	High Cholesterol	Stroke	Diabetes Type 1
Heart Disease	Anemia (what kind?)	Emphysema/COPD	Diabetes Type 2
Heart attack	________________	Asthma	GERD
Irregular heartbeat	Osteoporosis	Stomach Ulcers	Enlarged Prostate
Pacemaker (date inserted) ___________________	Glaucoma	Menopause	Seizures
	Migraines	Rheumatoid Arthritis	Hepatitis A
Varicose veins	Leg pain, itching, swelling	Osteoarthritis	Hepatitis B
AIDS	HIV	Dementia	Hepatitis C
Hypothyroidism	Hyperthyroidism	Stent placement (where?) ___________________	Alzheimer's disease
Defibrillator inserted (when?) _____________	Sleep Apnea		Dementia

> Any other diagnoses or chronic diseases: ____

____

> Have you been diagnosed with cancer? Yes No

Type cancer _______________Date diagnosed ________ Type cancer _______________Date diagnosed ________

> Do you use a CPAP machine? Yes No (Circle one.) > Do you use a BIPAP machine? Yes No (Circle one).

> For female patients, are you pregnant? Yes No (Circle one.) If yes, number of weeks gestation _______

> Are you a patient of a chronic pain management facility? Yes No

If yes, what is the name of the pain management facility? ____

Nature of pain? ____

> Have you had a colonoscopy? Yes No If yes, provide date ________________________

> Have you had an endoscopy? Yes No If yes, provide date ________________________

Past Surgeries	**Date**
List additional surgeries and associated dates on the back of this page.	

Patient's Signature____ Date_____________________

DENNIS L. FERNANDEZ, M.D., P.C.
General Surgery
4025 Pepperwood Circle SW, Suite C
Huntsville, AL 35801
Office: (256) 882-1908 • Fax: (256) 882-1907

Due to Federal Privacy Laws relating to the new HIPAA regulations we are unable to provide information to *anyone except you*, the patient regarding medical conditions, prescriptions, appointment times or any other information held by the practice *without your specific permission*.

If you desire your spouse, friends, parent, sister or brother or any other designated person to pick up prescriptions, make or check appointments, receive laboratory results or discuss your private medical information, please list that person's name below and sign and date this authorization.

I, ____ Date of Birth_________________________________

hereby authorize Dennis L. Fernandez, M.D., P.C. to release information from my medical records to include, but not limited to my complete medical record, prescription information, appointment or visit information, x-ray results, tests and test results, and laboratory results to the person/persons noted below.

I understand that this consent may be revoked at any time to the extent that disclosure made in good faith has already occurred in release of information on this consent.

Name____ Relationship__________________________

Name____ Relationship__________________________

Name____ Relationship__________________________

FOR TRANSFER OF MEDICAL RECORDS

I authorize Dennis L. Fernandez, M.D. PC and associated personnel to release my medical information to the following:

Name of Physician____

Name of Physician____

Name of Physician____

Dennis L. Fernandez, M.D., P.C. employees and officers, and attending physicians are released from legal responsibility or liability for release of the above noted information to the extent authorized herein.

Patient's Signature______________________________________ Date____________________________

If not signed by patient, relationship to patient ____

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PRESCRIPTION REFILL POLICY

Please read the following prescription refill policy carefully and sign below.

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 3:00 p.m. will not be received until the next day.
3. I understand that a follow up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I may not change the dosage or alter the time to take the medication without first speaking to my physician.
5. I must keep all appointments as recommended, so that prescription medications can be monitored.
6. I will not give, trade, or sell medication.
7. I will not alter or forge a prescription. This is a felony and will be reported.
8. I will not combine any narcotic medications with the consumption of alcohol.

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe pain medications to me.

Patient's Name____

Date ____

Signature____

My pharmacy's information is:

Name____

Location ____

Phone (   )____

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I have received the "Notice of Privacy Practices" and give my permission to Dennis L. Fernandez, M. D. PC to use and disclose my health information in accordance with the notice provided.

Patient's Name____

Signature____

Date ________________________

If not signed by patient, name and relationship to patient: _____________________________________

NOTICE OF PRIVACY PRACTICES

Dennis L. Fernandez, M.D., P.C.
https://HuntsvilleSurgery.com | Nancy Regan, Privacy Officer | 256-882-1908 | email: fernforms@earthlink.net
Effective Date of this notice: December 2, 2020

Your Information. Your Rights. Our Responsibilities.

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.** This medical practice collects health information about you and stores it on a computer and in an electronic health record. We utilize records of treatment, including taking photographs and videos, as required for insurance purposes, clinical documentation, and/or continuity of care.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- *Get an electronic or paper copy of your medical record*
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- *Ask us to correct your medical record.*
  - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - We may say "not to your request, but we'll tell you why in writing within 60 days.
- *Request confidential communications*
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- *Ask us to limit what we use or share*
  - You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- *Get a list of those with whom we've shared information*
  - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- *Get a copy of this privacy notice*
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- *Choose someone to act for you*
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- *File a complaint if you feel your rights are violated.*
  - You can complain if you feel we have violated your rights by contacting us using the information on page 1.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting *www.hhs.gov/ocr/privacy/hipaa/complaints/*.
  - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- *In these cases, you have both the right and choice to tell us to:*
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
  - Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- *In these cases, we never share your information unless you give us written permission:*
  - Marketing purposes, Sale of your information, Most sharing of psychotherapy notes
- *In the case of fundraising:*
  - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- *Treat you*: We can use your health information and share it with other professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition.
- *Run our organization:* We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- *Bill for your services:* We can use and share our health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- *Appointment Reminders:* We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
- *Change of Ownership:* In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
- *Cell Phone Authorization:* We can use the phone numbers and other contact information you provide, including cellular number and any future numbers assigned to you, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html*.

- *Help with public health and safety issues:*
  - We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone’s health or safety
- *Do research*
  - We can use or share your information for heath research
- *Comply with the law*
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
- *Respond to organ and tissue donation requests*
  - We can share health information about you with organ procurement organizations.
- *Work with a medical examiner or funeral director*
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- *Address workers’ compensation, law enforcement, and other government requests*
  - We can use or share health information about you: For workers’ compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.
- *Respond to lawsuits and legal actions*
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html*.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective date of this notice is: December 2, 2020