Jay S. Herbst, M.D., P.A.
SOUTH FLORIDA
SKIN CENTER
Skin Cancer Prevention and Treatment
2866-A Tamiami Trail • Port Charlotte, FL 33952
941.764.1055

PLEASE READ AND COMPLETE THE FOLLOWING FOR OUR RECORDS

This form must be completed the first scheduled appointment of the new year for us to update and/or confirm your patient information.

GENERAL INFORMATION

Prefix:_____ Name:_____ SS#: _____ Date of Birth: _____

Sex: _____ Marital Status: _____

Address:

Street: _____ City/State/Zip:_____

Out of State Address:

Street: _____ City/State/Zip:_____

Preferred Phone #: _____ □Cell □Home □Work Phone 2 #: _____ Phone 3 #:_____

If patient is a minor, has a guardian, or a Power of Attorney:

Full Name: _____ Phone: _____

All guardians and POAs must bring their legal paperwork as proof of guardianship or POA.

PHARMACY INFORMATION- Please fill out as much of this section as possible.
This information will be used to transmit (send) any medication prescribed during your visit.

Pharmacy: _____ Phone: _____ → I don't know □

Location:_____ (What is your pharmacy near?)

Who may receive medical information on your behalf?

Full Name: _____ Phone: _____ Relationship: _____

Full Name: _____ Phone: _____ Relationship: _____

May we leave appointment information on your answering machine? □ Yes □ No

EMERGENCY CONTACT INFORMATION:

Please give the name and phone number of a person NOT living with you.
This information is for your safety, in the event of an emergency or disconnected phone.

Full Name: _____ Phone: _____ Relationship: _____

Full Name: _____ Phone: _____ Relationship: _____

PLEASE PRESENT ALL INSURANCE CARDS TO A FRONT OFFICE MEMBER

NOTE: Your insurance contract and the benefits paid is between you and your insurance company. Our office is unable to negotiate any dispute you may have with your insurance company. You are responsible for payment of services provided. **Medicare Patients** are responsible for any deductible and 20% of Medicare approved amounts. This office does not file secondary insurance. Accounts 30 days past due will be subject to a late fee of $5. *For more information, please see our billing policy.*

AUTHORIZATION AND CONSENT

THIS DOCTOR'S OFFICE IS REGULATED PURSUANT TO THE RULES OF THE BOARD OF MEDICINE AS SET FORTH IN RULE CHAPTER 64B8, FLORIDA ADMINISTRATIVE CODE.

I hereby authorize Jay S. Herbst M.D., P.A. and/or his associates to administer treatment or perform such operations deemed necessary or advisable in diagnosis and treatment of myself/this patient. I hereby authorize the release of information or photographs necessary to file a claim with my insurance company, and I authorize payment of medical benefits directly to Jay S. Herbst M.D., P.A. as indicated on the claim. I understand that I am financially responsible for payment of professional services, including any balance that may not be covered by my insurance carrier, and for any past-due account billing fees.

Signed: _____ Date: _____

IF PATIENT IS A MINOR, THIS FORM MUST BE SIGNED BY A PARENT OR GUARDIAN. PLEASE SIGN ALL PAGES. THANK YOU.

Patient Name: _____

PLEASE READ AND COMPLETE THE FOLLOWING FOR OUR RECORDS

MEDICAL INFORMATION

Medications NONE ☐

_____

_____

Allergies (Please include reactions) NONE ☐

_____

_____ _____

Do you have, or have you had any of the following? NONE ☐

☐ Anxiety disorder	☐ Disease caused by 2019-nCoV	☐ Hypothyroidism
☐ Arthritis	☐ Elevated blood pressure	☐ Inflammatory disease of liver
☐ Asthma	☐ End-stage renal disease	☐ Leukemia
☐ Atrial fibrillation	☐ Epilepsy	☐ Malignant lymphoma
☐ Benign prostatic hyperplasia	☐ Gastroesophageal reflux disease	☐ Malignant tumor of breast
☐ Cerebrovascular accident	☐ H/O: hypertension	☐ Malignant tumor of colon
☐ Chronic obstructive lung disease	☐ Hearing loss	☐ Malignant tumor of lung
☐ Coronary arteriosclerosis	☐ HIV	☐ Malignant tumor of prostate
☐ Depressive disorder	☐ Hypercholesterolemia	☐ Radiation therapy treatment management
☐ Diabetes mellitus	☐ Hyperthyroidism	☐ Transplantation of bone marrow

☐ OTHER: _____

SURGICAL HISTORY: Have you had any of the following? ☐ NONE

☐ Abdominoperineal Resection	☐ Liver Excision	☐ Pancreatectomy
☐ Bilateral Replacement of Knee Joints	☐ Percutaneous Transluminal Coronary Angioplasty	☐ Percutaneous Extraction of Kidney Stone
☐ Biopsy of Breast	☐ Tissue Graft Heart Valve Replacement	☐ Portosystemic Shunt Operation
☐ Biopsy of Prostate	☐ Total Cystectomy	☐ Prostatectomy
☐ Coronary Artery Bypass Graft	☐ Transurethral Prostatectomy	☐ Prosthetic Arthroplasty of Bilateral Hips
☐ Entire Transplanted Kidney	☐ Hysterectomy	☐ Splenectomy
☐ Excision of Basal Cell Carcinoma	☐ Kidney Biopsy	☐ Surgical Biopsy of Skin
☐ Excision of Melanoma	☐ Low Anterior Resection of Rectum	☐ Total Nephrectomy
☐ Excision of Squamous Cell Carcinoma	☐ Lumpectomy of Breast	☐ Total Orchidectomy
☐ Colostomy	☐ Lumpectomy of Left Breast	☐ Total Replacement of Left Hip Joint
☐ Tubal Ligation	☐ Lumpectomy of Right Breast	☐ Total Replacement of Left Knee Joint
☐ Appendectomy	☐ Mastectomy of Left Breast	☐ Total Replacement of Right Hip Joint
☐ Bilateral Mastectomy	☐ Mastectomy of Right Breast	☐ Total Replacement of Right Knee Joint
☐ Cholecystectomy	☐ Mechanical Heart Valve Replacement	☐ Transplantation of Heart
☐ Colectomy		☐ Transplantation of Liver

☐ OTHER: _____

Signed: _____

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JAY S. HERBST, M.D., P.A. BILLING POLICIES

Patient Name: _____

Thank you for choosing Jay S. Herbst, M.D., PA. for your dermatologic needs. To help us provide good service, we ask that you read, sign, and return this agreement to a front staff member.

We only participate with GOVERNMENT ISSUED MEDICARE. We DO NOT participate with "Medicare-like" or "Medicare-partner" policies, or any other commercial insurance companies.

Initials _____

MEDICARE PATIENTS

We bill Medicare directly for professional services and accept their assignment.

Medicare pays us 80% of their approved prices. You are responsible for the remaining 20%.

We will keep your secondary insurance on file, but CAN NOT GUARENTEE submission of secondary claims if your claim does crossover from Medicare.

You will be required to pay any remaining balance after your charges have been adjusted and paid by Medicare and your secondary insurance company.

Each year you must meet the Medicare deductible before Medicare starts paying for provided services.

We do not collect Medicare deductibles until we receive an explanation of benefits assigning your deductible to our office.

If you think you have paid another doctor your deductible, and it has not been processed by your insurance company, you may still be responsible for paying your deductible to us. We will not contact another doctor's office on your behalf to refund you any payment they may have collected from you before receiving an explanation of benefits.

You will be billed for any charges not paid by your secondary insurance company within 30 days of Medicare's payment.

Initials _____

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JAY S. HERBST, M.D., P.A. BILLING POLICIES (cont.)

WHEN IS PAYMENT DUE AT TIME OF SERVICE?

If you do not have insurance, you will be required to pay in full at time of service.

If you have insurance other than government issued Medicare, you may be required to pay a copay or coinsurance at time of service.

You may be required to pay in full at time of service, pay a copay, or pay coinsurance if we are unable to verify your insurance benefits, or your insurance company is unable to be added to our system.

We do not participate with Champus insurance. Charges are the Champus approved fees, and are due at time of service.

If you are having a non-covered procedure you may be expected to pay at time of service.

You have debt to this office due to your non-payment of billed charges, regardless of your chosen insurance company, including Medicare.

Initials _____

Your contract for benefits is between you and your chosen insurance company*.** We will do our best to collect payment from your insurance company, but your contract with your insurance company is not negotiable by this office. ***It is your responsibility to understand your chosen policy and benefits.

Initials _____

Acknowledgement of Receipt of Billing Agreement

I acknowledge that I have received the South Florida Skin Center Billing Agreement and understand that I have the opportunity to ask questions regarding our billing practices. I also understand that Jay S. Herbst M.D., P.A. reserves the right to modify practices outlined in the agreement, in its entirety or on a per patient basis.

_____ _____

Patient/Guardian Signature Date

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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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

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 "no" 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 *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.

Our 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.	***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.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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 health 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 web site.

SFSC | SOUTH FLORIDA SKIN CENTER
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Name of Patient (Print)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Jay S. Herbst, M.D., P.A., reserves the right to modify practices outlined in the notice.

I acknowledge that I have received the attached privacy notice.

Signer: ☐ Patient ☐ Patient Representative

Signature of Patient or Patient Representative

Date

Name of Patient Representative

Relationship of Patient Representative to Patient

ATTACHMENTS

Please attach your driver's license, insurance cards, and any medication lists you may have.

Please arrive 15 minutes before your appointment, and if you are unable to attach your cards or documents, bring them with you to your appointments so we can enter them into our system.