Thank you for choosing Menard Plastic Surgery! We know your time is valuable. In an effort to shorten your wait time we have included Patient Forms for your completion.

Please be aware that it will take approximately one hour for our staff to enter your information into our computer system. If we do not receive your paperwork at least **3 days prior** to your appointment there is a possibility your appointment could be rescheduled. If you cannot get your paperwork to us via email, drop off, or fax 3 days prior to your appointment, please arrive 1 hour early to give yourself enough time to complete the forms and our staff to get everything entered in our system.

*Scan and email your completed forms to:
lwalker@menardplasticsurgery.com
kpetersen@menardplasticsurgery.com

*Fax your completed forms to (205) 391-4688.

* Drop them off by our office
401 Towncenter Blvd Suite B
Tuscaloosa, AL 35406

*Be sure to include a copy of the front and back of your insurance card/s and photo ID.

If you have any questions, please call us at (205) 391-9038.
We look forward to meeting you!

Sincerely,

L. WALKER
Receptionist
Menard Plastic Surgery
P: (205) 391-9038 | **F:** (205) 391-4688

Patient Forms for Appointment on Monday at

Patient Forms for Appointment on Wednesday at

MENARD
PLASTIC SURGERY

WELCOME TO OUR NEW ELECTRONIC HEALTHCARE SECURE PATIENT PORTAL

As a part of the Federal Government's Electronic Health Record Initiative, patients are now provided the ability to view online, download and transmit their health information. This involves setting up your own secure patient portal. To help us set up your secure portal and subsequently transmit to your portal summary of today's visit, we will need the flowing information. Your temporary username and password will be provided to you as well as instructions on how to visit your portal at home.

Patient Name____

Email Address____

** We will be glad to assist you in our office to help set up and establish your patient portal username and password. Just let one of our staff members know and we will set it up for you.

HOW TO VISIT YOUR PATIENT PORTAL FROM HOME

SETTING UP YOUR PASSWORD

1. Visit https://patlogin.medconnect-inc.com/Login.aspx
2. Enter username, temporary password and passcode given to you by our office and click LOG IN.
3. It will now prompt you to re-enter your **temporary password**, a **new password** and to confirm your new password again. You must follow the guidelines for choosing a password that are given on the right side of the screen. As you are typing your password, it will determine if your password **PASSES OR FAILS.** You must select a password that passes before it will let you click **UPDATE**.
4. Once you have successfully selected a password, you will be directed to the home screen in your patient portal.

CONTACT US BY E-MESSAGING VIA PATIENT PORTAL

- Go to the tab labeled **MESSAGING.**
- Select **COMPOSE MESSAGE**.
- Under **STAFF GROUP** section of the composed message, click the dropdown box and select
- **Dr. Menard Care Team.**
- Add a **Subject** on the **Subject Line**.
- Type a Message and click **SEND MESSAGE**

Our staff will review your message and you will receive a response. Contact our office at **205-391-9038** if you have not received a response within 48 hours.

VIEW YOUR DOCUMENTS

Go to the **DOCUMENTS** tab and **highlight** any visit under CCDA Documents. Click **VIEW FULL CCDA.**

Once we have received your email, we may e-message you through the patient portal. Feel free to send a non-emergency message if you have any questions or comments. ***Please do not use this for emergencies.***
Call 911 or go to your nearest Emergency Room.

PATIENT DATA FORM

_______________ _______________ _______________ _______
Last Name First Name Middle/Maiden Date

_______ _______________ ____ _________ M___S___W___D___
Birthdate Patient's SS# Sex Race

Patient's Mailing Address:

____

Patient's Email Address:

____

Home Phone _______________________ Work Phone _______________________
Cell Phone_______________________ My cell phone carrier is: _______________
I give my permission to Menard Plastic Surgery to leave a message on my cell phone: ___Y ___N

Spouse's Name_______________________________ Phone # _______________
Insurance Primary_______________________ Secondary_______________________
Policy #_______________________ Group #_______________
Policy Holder's Name_______________________________ DOB _______________
Reason for Visit____

Relative to Contact in Case of Emergency (*other than spouse*)

Name_______________________Relationship_______________Phone ___________

Is this a Workman's Compensation injury? ____N ____Y Date of Accident/Injury _______________

Primary
Physician____
Name Phone # City

Referring Physician____
Name Phone# City

Preferred Pharmacy____
Name Phone# Location

Please List the Names of those Authorized by You to Receive Your Medical Information (Family/Friends)

____

____

Menard Plastic Surgery
MEDICAL HISTORY FORM

LAST NAME	FIRST NAME	MIDDLE/MAIDEN	DATE

DOB	AGE	Marital Status	# of Children	Height	Weight	Occupation

PLEASE CIRCLE Y (YES) N (NO)

N Y Are you a Jehovah's Witness If Yes, PLEASE Notify Your Nurse
N Y Do you have an Advanced Directive? Such as A Living Will or Durable Power of Attorney
N Y Are you Pregnant?
N Y Do you Exercise How Often? ____________________
N Y Do you Smoke Packs /day ____________How many Years? ________
N Y Do you Drink? How Often? ____________________
N Y Have you fallen in the past year?
N Y Is this visit related to an injury? Date of onset ____________
N Y Are you Allergic to Latex?
Are you RIGHT handed or LEFT handed (Please circle one)
Dates of Your Last Shots: Tetanus ____________ Flu____________ Pneumonia____________
Have you been HOSPITALIZED in the past year?
__NO __YES (Please explain)

____

N Y Medication Allergies? Please Explain: ____________________

PATIENT'S CURRENT MEDICATIONS AND DOSAGE:

1.____________ 6.____________
2.____________ 7.____________
3.____________ 8.____________
4.____________ 9.____________
5.____________ 10.____________

Family Medical History: Has a Family Member had any of the following health conditions?
Please indicate which family member using F (*Father*) M (*Mother*) S (*Sibling*) GF (*Grandfather*) GM (*Grandmother*)

Stroke____________ Diabetes ____________
Heart Disease____________ High Blood Pressure____________
Cancer ____________
Type of Cancer____________
Problems with Anesthesia ____________
Bleeding Disorder____________Other____________

PATIENT/GUARDIAN SIGNATURE ____________ DATE ____________

PAST MEDICAL HISTORY

Patient Name____Date______

Please Circle Y (YES) or N (NO) if you have had the following medical conditions now or in the past:

Heart:
- Y N Coronary Disease
- Y N MI/Heart Attack
- Y N Congestive Heart Failure
- Y N Atrial Fibrillation
- Y N Angina
- Y N Valve Disorder
- Y N Pace Maker
- Y N High Cholesterol
- Y N Hypertension

Neurological:
- Y N Stroke
- Y N TIA
- Y N Seizures
- Y N Bell's Palsy
- Y N Sleep Apnea

Blood Clots
- Y N Lung
- Y N Legs

Kidney:
- Y N Infection
- Y N Failure
- Y N Stones

Arthritis:
- Y N Osteoarthritis
- Y N Rheumatoid
- Y N Psoriatic

Diabetes:
- Y N Type I
- Y N Type II

GI:
- Y N Ulcers
- Y N Pancreatitis
- Y N Diverticulitis

Psychological:
- Y N Anxiety
- Y N Depression
- Y N Bipolar
- Y N OCD
- Y N ADHD

Chronic Pain:
- Y N Back
- Y N Fibromyalgia
- Y N Neuropathy

Other: ________________

PRIOR SURGERIES & DATES:

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

Have you had any problems with Anesthesia? ____NO ___ YES (Please Explain)

____

Did you have any problems with Abnormal Bleeding? ____NO ____YES (Please Explain)

____

NURSES' NOTES:

____

____

____

____

____

____

MENARD

PLASTIC SURGERY

REVIEW OF SYSTEMS

Have you had recent onset of any of the following?

GENERAL HEALTH

CURRENT WEIGHT ______ HEIGHT______

YES_____ NO_____ WEIGHT GAIN OR WEIGHT LOSS
YES_____ NO_____ FATIGUE/LACK OF ENERGY
YES_____ NO_____ LOSS OF APPETITE

EARS, NOSE, MOUTH, THROAT

YES_____ NO_____ HEADACHE
YES_____ NO_____ FACIAL PAIN
YES_____ NO_____ HEARING LOSS
YES_____ NO_____ NECK PAIN
YES_____ NO_____ VISUAL CHANGES

HEART & BLOOD VESSELS

YES_____ NO_____ CHEST PAIN
YES_____ NO_____ IRREGULAR HEARTBEAT
YES_____ NO_____ SWELLING OF FEET OR LEGS

LUNGS & BREATHING

YES_____ NO_____ SHORTNESS OF BREATH
YES_____ NO_____ COUGH
YES_____ NO_____ USE OF HOME 02
YES_____ NO_____ USE OF CPAP

STOMACH & INTESTINES

YES_____ NO_____ ABDOMINAL PAIN
YES_____ NO_____ NAUSEA/VOMITING
YES_____ NO_____ APPETITE CHANGES

PYSCHOLOGICAL

YES_____ NO_____ ANXIETY
YES_____ NO_____ DEPRESSION
YES_____ NO_____ MENTAL HEALTH ISSUES

NEUROLOGICAL

YES_____ NO_____ SYNCOPE
YES_____ NO_____ DIZZINESS

SKIN & BREAST

YES_____ NO_____ NIPPLE DISCHARGE
YES_____ NO_____ BREAST PAIN
YES_____ NO_____ BREAST LUMP

MENARD

PLASTIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ____

Print Patient's Name

Hereby authorize any and all physicians or entities involved in my medical care to disclose my health information to:

Menard Plastic Surgery, PC
401 Towncenter Boulevard
Suite B
Tuscaloosa, Al 35406
Telephone: 205-391-9038
Fax: 205-391-4688

Information to be released:	**Entire Medical Record**
Date of Services:	**Entire time under care of Physician**
Purpose of Information:	**Continuity of Care**

This authorization may be revoked at any time by providing a written notice of revocation to the manager at Menard Plastic Surgery, PC except to the extent that the provider above has already taken action in reliance on it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules. This authorization will terminate in one year.

______________________________________ ________________

Patient or Guardian Signature **Date**

MENARD

PLASTIC SURGERY

Consent for the Release of Photographs

I, ____ authorize the use of my photographs in the forums listed below. I waive any right to inspect or approve the finished product, advertising, or any other copy that may be used in connection with the options below. I understand that I will **never** be identified by name in any use of these photographs but that in some circumstances, the photograph may portray features which make my identity recognizable.

Please **initial** YES or NO for each of the items below.

_______**YES** _______**NO**

I agree to the use of my photos in the **office photo gallery** to help future patients understand and see outcomes from surgery with Menard Plastic Surgery.

_______**YES** _______**NO**

I agree to the use of my photos on the Menard Plastic Surgery **website or affiliated websites** for prospective patients to understand and see outcomes from surgery with Menard Plastic Surgery.

I release and discharge Menard Plastic Surgery from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above authorization and fully understand the terms.

Print Name_________________________________ **Date**________________

Signature____

Witness____

This consent may be revoked at any time with a written Notice of Revocation.

MENARD
PLASTIC SURGERY

CONSENT FOR USE OF PHOTOGRAPHS

Medical photographs are routinely obtained in order to help the surgeon plan the meticulous details of each operation. You will be photographed in the office as part of your initial consultation, and then at regular intervals during post-operative visits. These pictures become an integrated part of your medical record and shall be the property of Menard Plastic Surgery, PC.

I HEREBY CONSENT to be photographed by the staff of Menard Plastic Surgery, PC.

____________________	____________________	__________
Print Name	Signature of Patient or Legal Guardian	Date
	____________________	__________
	Signature of Witness	Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

____________________	____________________	__________
Print Name	SS# or Health Record Number	Patient DOB

I authorize Menard Plastic Surgery, PC to release/disclose my health information, including my entire medical record, to any and all physicians or entities involved in my medical care.

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

____ Date______________

Signature of Patient or Legal Guardian

This authorization expires 12 months from the date signed.

INSURANCE AUTHORIZATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to either myself or to the party who accepts assignment. I authorize payment of medical benefits to the above physician or supplier for services described on their claim forms.

____

Patient 's Printed Name

____ ______________

Signature of Patient/Responsible Party **Date**

I acknowledge and understand that I am responsible for the payment of all charges incurred on my behalf as a patient, incurred on behalf of my family member who is a patient, or incurred on behalf of the patient for whom I have deed to act as responsible party. Surgical procedures relating to trauma, disease and reconstruction can be filed on my medical insurance coverage. The portion, which my insurance does not cover, is my financial responsibility. All cosmetic procedures are to be paid 14 days in advance prior to the date of surgery.

In the event my account is not paid within 30 days, I agree to pay all costs and expenses of collection irrespective of whether suit is filed or not, including, but not limited to, a reasonable attorney's fee, court costs, and like, regardless of whether Menard Plastic Surgery, PC initiates the collections procedure itself or refers my account to an attorney for collection. I further agree to pay interest at 1.5% per month (18% annual percentage rate) on the outstanding portion of my account including unpaid interest until paid in full, and hereby waive all rights of exemption under the Constitution of the State of Alabama.

HIPAA NOTICE OF PRIVACY PRACTICES

Menard Plastic Surgery, PC
401 Towncenter Boulevard, Suite B
Tuscaloosa, Al 35406
205-391-9038 (Fax # 205-391-4688)

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Signature below is only acknowledgement that you have received this Notice or the information therein:

Printed Name: ______________________________

Signature: ______________________________

Date: ____________________

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality or your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control you PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any question with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices
We are required to follow the terms of this notice. We reserve the right to change the terms or our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure-This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke on an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken on action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication-This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI-This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional state or federal guidelines.

You have the right to request a restriction of your PHI- This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for you treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information-This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability-This means that you may request a listing of disclosures that we have made of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice-You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.
If you have questions regarding your privacy right, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How we May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment- We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Provides who may be involved on your care and treatment.

Special Notices-We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment- Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations- We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization- The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare-Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures- We are also permitted to use or disclose your PHI without your written authorization for the flowing purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral director; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager at: Menard Plastic Surgery, 401 Towncenter Blvd. Suite B, Tuscaloosa, Al 35406 or call 205-391-9038 and ask to speak to our Office Manager.

M E N A R D

P L A S T I C   S U R G E R Y

John W. Menard, M.D., F.A.C.S.

Diplomate, American Board of Plastic Surgery · Fellow, American College of Surgeons

Cosmetic and Reconstructive Surgery

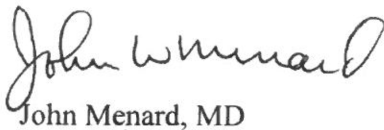
To Our Patient:

Due to the current public health environment and guidance from governmental authorities, our office has made many changes to protocol and policy in order to increase protection from COVID -19 for you, our patient and our employees.

Social distancing plays a vital role in combating the spread of the virus. However, social distancing is not possible when undergoing surgical care and we ask that you acknowledge this fact with your signature.

Please let us know of any questions or concerns.

Thank you,



John Menard, MD

Please print name ____

__________________________________ ____________________

Patient or Guardian Signature Date