FREDERICK J. MENICK, M.D.

Diplomate of the American Board of Plastic Surgery

Welcome to our Office

Date: _____

Patient Information

Last Name: _____First Name: _____M.I._____

Address: _____City:_____ST_____Zip_____

Home# _____ Cell# _____ Height_____Weight_____

Social Security# _____ D.O.B _____/_____/_____(Age _____) Male or Female

Patient Status: ( )-single ( )- married ( )-separated ( )-divorced ( )-widowed ( )-other

Employer Name _____Phone#_____

Address: _____City:_____ST_____Zip_____

Reason for Visit? _____

How were you referred to Dr. Menick? Yellow Pages____ Dex online____ Internet____ Friend____

Dr. Menick's website____ Physician/name_____Other_____

Emergency Contact: Name_____ phone #_____

Your E-mail Address:_____

Authorization to release information and assignment of benefits: I hereby authorize Dr. Menick to release any medical information necessary to process my claim(s) to my insurer, and also authorize payment to be made directly to Frederick J. Menick, M.D.

Consent to be photographed: I consent to the photographing of my pre-operative, operative and post-operative condition and the procedures performed. This material may be used for medical, and professional activities, including the INTERNET to provide information and educational materials to medical professionals and the public. I am over 18 years of age.

Patient Signature _____ Date _____

Medical History

Patient Name _____ Today's Date _____

Past Medical History/ Review of Systems (do you currently have or have you ever had any of the following)

Skin
- ☐ atypical moles(nevi)
- ☐ pre-cancer lesions
- ☐ basal cell carcinoma
- ☐ squamous cell carcinoma
- ☐ melanoma
- ☐ abnormal scarring/keloids
- ☐ other_____
- ☐ NORMAL

Musculoskeletal
- ☐ artificial joints
- ☐ arthritis
- ☐ muscle weakness
- ☐ fibromyalgia
- ☐ other_____
- ☐ NORMAL

Neurological
- ☐ stroke
- ☐ seizure (epilepsy)
- ☐ neuralgia
- ☐ numbness/tingling
- ☐ other_____
- ☐ NORMAL

Cardiovascular
- ☐ high blood pressure
- ☐ chest pain
- ☐ heart attack
- ☐ pacemaker
- ☐ artificial heart valve
- ☐ other_____
- ☐ NORMAL

Respiratory
- ☐ asthma
- ☐ emphysema
- ☐ cough
- ☐ other_____
- ☐ NORMAL

Gastrointestinal
- ☐ stomach ulcer
- ☐ colitis
- ☐ liver problems
- ☐ other_____
- ☐ NORMAL

Hematologic/Lymphatic
- ☐ anemia
- ☐ bleeding problems
- ☐ enlarged lymph nodes
- ☐ other_____
- ☐ NORMAL

Eye/Ear/Nose/Throat
- ☐ glaucoma
- ☐ hearing aid
- ☐ plastic surgery
- ☐ other_____
- ☐ NORMAL

Psychiatric
- ☐ depression
- ☐ anxiety
- ☐ dementia
- ☐ other_____
- ☐ NORMAL

Endocrine
- ☐ diabetes
- ☐ thyroid
- ☐ oral steroid use
- ☐ other_____
- ☐ NORMAL

Infections
- ☐ hepatitis A, B, C
- ☐ HIV / AIDS
- ☐ tuberculosis / TB
- ☐ other _____
- ☐ NORMAL

Urologic
- ☐ dialysis
- ☐ kidney problems
- ☐ venereal disease
- ☐ other_____
- ☐ NORMAL

Immune
- ☐ lupus
- ☐ organ transplant
- ☐ cancer chemotherapy
- ☐ other_____
- ☐ NORMAL

Constitutional
- ☐ weight loss
- ☐ fever
- ☐ chills
- ☐ other_____
- ☐ NORMAL

- Are you currently pregnant, planning to become pregnant, or nursing?..... Yes No
- Does your Dentist ask you to take Antibiotics before dental work?..... Yes No
- Are you allergic to latex?..... Yes No
- Do you routinely wear sunscreen?..... Yes No
- History of MRSA or VRE? Yes No

Surgeries (skin cancer and all surgeries): _____

Hospitalizations/ other Illnesses: _____

Medications (Include over the counter meds. and vitamins): _____

Allergies (medications, food): _____

Social History: Tobacco Use: No____ Yes ____ (age started ____ amount per day ____ age quit ____ currently using _____)
Alcohol: No ____ Yes ____ (amount per day/week _____)

Family History (blood relatives only list relationship to you):

☐ skin cancer _____ ☐ other skin problems _____ ☐ other medical problems _____ ☐ none known _____

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Acknowledgment of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

Dr. Frederick J. Menick
Email consent form

Patient name: _____
Patient address: _____
Email: _____

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can accidentally misaddress an email
c) Copies of email may exist even after they have been deleted by the sender and/or the recipient.
d) Employers have the right to inspect all emails transmitted through their systems
e) Email can be altered, intercepted, forwarded, or used without authorization or detection. Email may not be secure. Email can be used to introduce viruses.
f) Email can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will usually be printed and filed in the patient's medical record.
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails outside of our practice without the patient's prior consent except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

3. INSTRUCTIONS

To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email. Key in the topic (e.g., medical question, billing question) in the subject line.
c) Inform Provider of the changes in his/her email address. Acknowledge any email received from the Provider.
d) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with Dr. Frederick J. Menick.

Patient signature & Date: _____
Witness signature & Date: _____

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DIPLOMATE OF THE AMERICAN BOARD OF PLASTIC SURGERY

FINANCIAL POLICY

Thank you for choosing Dr. Menick as your plastic surgeon. We sincerely appreciate your trust and the opportunity to serve you. As part of our commitment to service, we make every effort to offer efficient and helpful billing services. It is required that you read, understand, and sign the following financial policy prior to any evaluation or treatment.

Non-participating plans:

As a courtesy to you, we will provide you with complete insurance information. Since we do not participate with your plan, the insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please notify us if you have contacted your insurance company and there is additional information that we may provide to help settle the claim. Your insurance company may not reimburse any or all of your claim. Most insurance plans only reimburse a percentage of their allowable charges.

Usual and Customary Rates:

Our practice is committed to providing the best care for our patients. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

Final considerations:

Cosmetic surgery is not covered by insurance and is your full responsibility. Surgical fees must be paid in full prior to surgery. There are no exceptions. A $300.00 deposit is required when scheduling surgery to reserve the surgery time. The deposit as well as one consultation fee will be applied to the total amount of the surgery fee. If you cancel the surgery at least five working days before surgery, the deposit will be refunded. The remainder of the fee must be paid at least five working days before the surgery date by cash, cashiers check, money order, Visa or Master Card. If you pay with an Arizona check, the check must be received at least 2 weeks prior to the surgery date. An out of state check must be received at least 3 weeks before surgery. If these financial requirements are not met, your surgery is subject to cancellation without notice.

If at any time you have questions regarding cost of procedures proposed, you may ask for someone from the financial office to discuss anticipated costs with you.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this financial policy.

_____ _____

Patient Signature/ Responsible Party **Date of Signature**