PLEASE NOTE

No children are allowed in our office unless they are a patient of Dr. Francel.

Many of our breast cancer patients are undergoing chemotherapy. Their resistance is low and they are more susceptible to infections.

NO FOOD OR DRINKS ALLOWED

We appreciate your cooperation

Thomas J. Francel, M.D., F.A.C.S.
Plastic Surgery, P.C.
621 South New Ballas Road, Suite 1009-B
St. Louis, Missouri 63141
314/251-6845

PATIENT INFORMATION

Today's Date _____ Social Security # _____

Name _____
Last First Middle Initial

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Email _____

Sex ☐ Male ☐ Female Birthdate _____ Age _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Employer _____ Occupation _____ Phone _____

Address _____ City/State/Zip _____

Name of nearest relative not living with you _____ Phone _____

Who may we thank for referring you? _____

SPOUSE'S INFORMATION

Name _____ SSN _____

Address _____ City/State/Zip _____

Home Phone _____ Date of Birth _____ Employer _____

Occupation _____ Work Phone _____

Address _____ City/State/Zip _____

INSURANCE PLAN INFORMATION

1) Plan Name _____ Address _____

City/State/Zip _____ Policy/Group # _____

ID # _____ Policy Owner _____

2) Plan Name _____ Address _____

City/State/Zip _____ Policy/Group # _____

ID # _____ Policy Owner _____

"I authorize treatment/consultation for myself by Dr. Francel"

_____
Patient or Authorized Signature

"I verify the accuracy of the information on page 1 of the patient information sheet, and I authorize the release of any medical information to process any claims."

_____
Patient or Authorized Signature

"I request payment of this claim and authorize payment directly to the physician or supplier for the services provided. I hereby agree to pay any and all charges that exceed or that are not covered by insurance."

_____
Insured Signature - Date

Cosmetic Consultation Fees, Copayments, and All Services not covered under your insurance plan are due at the time of service. Thank you.

HEALTH INFORMATION

Name _____ Age _____ Referred By _____

Height _____ Weight _____ Personal Physician _____

1) Is your general health good? ☐ Yes ☐ No

2) Do you have a family history of any illness? ☐ Yes ☐ No

If yes, please list _____

3) Are you allergic to any medications, drugs or local anesthetic? ☐ Yes ☐ No

If yes, please list _____

(Please check any of the following that apply to you)

4) Have you ever had any of the following:

Yes	Yes	Yes
☐ Heart Attack	☐ Mitral valve prolapse	☐ Diabetes
☐ Heart failure	☐ Rheumatic fever	☐ Connective Tissue Disorder
☐ Irregular heartbeat	☐ Heart valve replacement	☐ Stroke
☐ Chest pain	☐ Heart valve disease	☐ Blood disorder
☐ Shortness of breath	☐ High blood pressure	☐ Anemia
☐ Excessive bleeding	☐ Clotting disorder	☐ Easy bruisability
☐ Thyroid disorder	☐ Hepatitis	☐ Stomach ulcer problems
☐ Excessive scarring	☐ Colon problems	☐ Kidney problems
☐ Seizures	☐ Formation of keloids	☐ Depression
☐ Asthma	☐ Arthritis	

☐ Cancer - please list type _____

5) Do you take any medications on a regular basis? ☐ Yes ☐ No

If yes, please list

_____ _____ _____

_____ _____ _____

_____ _____ _____

6) Do you take aspirin, Advil, or anti-inflammatory medication more than once a week? ☐ Yes ☐ No

7) Do you smoke? ☐ Yes ☐ No

How much? _____ Date you quit? _____

8) Do or did you ever have a problem with chemical dependency? ☐ Yes ☐ No

9) Have you ever had surgery or been hospitalized for any reason? ☐ Yes ☐ No

If yes, please list

Previous Surgeries/Hospitalizations	Dates
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or Legal Guardian's Signature _____

Physician's Initials _____ Date _____

THOMAS J. FRANCEL, M.D., F.A.C.S.

Chief of Plastic Surgery

St. John's Mercy Medical Center
621 S. New Ballas Road, Suite 1009-B
St. Louis, MO 63141
(314) 251-6845 Fax: (314) 251-5754

FORWARDING PAYMENT AGREEMENT

Dr. Thomas Francel, M.D., P.C. is not an in network provider for any insurance company, including Medicare. Certain insurance companies pay the patient directly. The payment you receive directly from your insurance company is payment for your surgery and/or procedure.

The patient/person responsible for any payment on this account, in addition to agreeing to be financially responsible for paying all amounts due, shall forward payment immediately upon receipt from any insurance company for surgery and any procedure made payable to Thomas J. Francel, M.D., P.C. Any payment received directly by patient/person from any insurance company, shall be forwarded to this office within 7 days of receipt by patient/person responsible for this account. Payment for any "amount due" shall be made within 30 days of demand being made. Interest shall accrue at a rate of 1½% per month, 18% per annum on any amount due and added to amount due. In the event that a discount has been granted to the patient and payment from patient/person responsible has not been received within 30 day of demand being made, the discount will be void resulting in the patient/person being liable for the full amount originally billed to the insurance company, prior to any discount applied. In the event that any collection efforts are initiated by Thomas J. Francel, M.D., P.C., the patient/person responsible for this account agrees to be responsible and pay Dr. Thomas Francel, M.D. P.C. court costs and attorney fees. This agreement constitutes the entire agreement and no verbal agreements are valid.

PLEASE READ CAREFULLY. BY SIGNING PATIENT/PERSON RESPONSIBLE ACKNOWLEDGES THAT THEY HAVE READ AND UNDERSTOOD THIS AGREEMENT.

Patient/Person Responsible for Account Date

HIPAA Notice of Privacy Practices

Name

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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

PLEASE SIGN THE REVERSE SIDE AND SUBMIT WITH YOUR PATIENT INFORMATION SHEETS

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary 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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____