KM PLASTIC SURGERY

**Patient Name**: _____
First Middle Last

Address: _____
Street & Apt # City State Zip

**Check preferred phone**

☐Cell Phone: _____ ☐Home Phone: _____

Email: _____

Birthdate: _____ SS# _____ Sex: M F

Preferred Language: _____ Race/Ethnicity: _____

**Referred By**: _____

**Patient's Employer**: _____ Occupation: _____

Work Phone: _____ Ext: _____

**Emergency Contact Name**: _____

Phone: _____Relationship to Patient: _____

I am covered by Medicare or Medicaid: Yes ☐ No ☐

I am interested in a complementary ***FACIAL CONSULTATION*** by a Master Aesthetician ☐**Yes** (if yes, check areas below) ☐**No**

| | | | |
|---|---|---|---|
| ☐Botox/Facial Fillers | ☐Tattoo Removal | ☐Chemical Peels | ☐Facials |
| ☐Acne | ☐Brown Spots | ☐Skin Discoloration | ☐Wrinkles |
| ☐Redness | ☐Large pores | ☐Brow Wax/Tint | ☐Skin Care Products |
| ☐ Permanent Cosmetics | | | |

Other: _____

I understand that office visit charges are payable on the day service is rendered. I am responsible for all bills being paid in a timely manner. I understand that my contract is between KM Plastic Surgery and myself.

**Signature:** _____ **Date:** _____

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Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer to the best of your knowledge.

Name: _____ Reason for Visit: _____

Height: _____ Weight: _____

Primary Care Physician: _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any major-medical conditions you have been diagnosed with:

History of keloid scarring? ☐Yes ☐No
History of Cold Sores? ☐Yes ☐No
Use of Steroids? ☐Yes ☐No

Number of Pregnancies: _____
Planning Future Pregnancy? ☐Yes ☐No
Have you breast fed in the past? ☐Yes ☐No
Date of Last Mammogram: _____ Result: _____

Number of Children: _____
Is there any chance you are currently pregnant? ☐Yes ☐No
Possibility of Breast Feeding in the Future? ☐Yes ☐No

Do you have or have you had any of the following: (circle for each)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aids | No | Yes | Seizures | No | Yes | High Blood Pressure | No | Yes |
| HIV | No | Yes | Fainting | No | Yes | Kidney Problems | No | Yes |
| Arthritis | No | Yes | Weakness/Paralysis | No | Yes | Sinus Problems/Infections | No | Yes |
| Asthma/COPD | No | Yes | Thyroid Problems | No | Yes | DVT/Blood Clots | No | Yes |
| Bronchitis/Pneumonia | No | Yes | Seasonal Allergies | No | Yes | Nausea | No | Yes |
| **Cancer** | No | Yes | Headaches/Migraine | No | Yes | Heartburn/GERD/Indigestion | No | Yes |
| **Type of Cancer:** | | | Heart Trouble/Attack | No | Yes | Auto Immune Disease | No | Yes |
| Depression/Anxiety | No | Yes | EKG Abnormalities | No | Yes | Hepatitis | No | Yes |
| Diabetes | No | Yes | Stroke | No | Yes | Chronic Pain | No | Yes |
| Dizziness/Vertigo | No | Yes | Chest Pain | No | Yes | | | |

Are you: ☐Unemployed ☐Employed ☐ Retired
Do you live: ☐Alone ☐With Spouse ☐With Children ☐With Others: List_____
Drink alcohol? ☐Never ☐Daily ☐ Weekly ☐Occasional ☐History of Alcohol Abuse How much? _____

Smoking? ☐ No ☐ Quit Date _____ ☐ Currently Smoke _____Cigarettes a day? _____

Do you use recreational Drugs? ☐No ☐Yes – What kind? _____

| |
|---|
| List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency. |
| List ALL drug and/or latex allergies and reaction. |
| Family History: Please list any major medical problems and relation of your immediate family. |
| Preferred Pharmacy. Location and phone #. |

**The above information is accurate and complete to the best of my knowledge.**

**Signature _____** **Date _____**

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**NOTICE OF PRIVACY PRACTICES HIPAA –**
**ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information from KM Plastic Surgery. Available upon request.

By my signature below I acknowledge receipt of the 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)

This form will be retained in your medical record.

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# COMMUNICATION CONSENT AND AUTHORIZATIONS

*Please check the information you wish to authorize.

____ I give my consent for KM Plastic Surgery or staff to leave information regarding my treatment, results, appointment information or recommendations on my **VOICEMAIL** at the phone numbers I have provided.

____ I give my permission for KM Plastic Surgery or staff to **PHONE** me at my work.

____ I give my permission for KM Plastic Surgery or staff to **TEXT** me.

Mobile Phone #_____ Mobile Carrier _____
(Ex. Verizon, AT&T etc.)

____ I give my permission for KM Plastic Surgery or staff to discuss my billing information and appointment information with the person/persons listed below:

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

____ I give my permission for lab results to be sent to me at the address I have supplied.

____ I give my permission to opt into email notices of product/services, special pricing or new technology notices at the email address I have provided.

I am aware that I may change the above authorizations with a written request at any time. The new authorization will only become effective once a written request is received by KM Plastic Surgery.

My signature acknowledges that I have read and agree to the authorizations I have selected above.

Print Name: _____

Patient Signature: _____ Date: _____

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# PHOTO AND VIDEO CONSENT AND AUTHORIZATION

I, _____, authorize the capture, disclosure and use, as noted below, of photographs, video and **accompanying protected health information** related to my healthcare services at Kai Morimoto MD, PLLC. I understand that my photo will be taken and placed in my permanent medical record.

Media may be used for:

**□ Yes □ No** – In-office Computer Photo Album for the education of KM Plastic Surgery patients.

**□ Yes □ No** – Publication on the KM Plastic Surgery website or in other advertising media representing and/or marketing for Kai Morimoto MD, PLLC and services. Published media may include my image, voice, age, sex, medical condition, treatment and outcome, but this consent does not authorize the release of written or printed medical records. However, please withhold the following specific information:

_____

All Media will become the property of KM Plastic Surgery and may be retained for the purposes and uses approved in this consent. I understand that KM Plastic Surgery may receive compensation for its use and/or disclosure of Media in marketing materials such as websites, media outreach, brochures, television, and/or any other media outlets or for other marketing purposes. I understand and agree that I will not receive any compensation for use of Media and I waive any right for myself, my spousal community or my heirs and assigns to receive any compensation. I agree to hold harmless KM Plastic Surgery and its associated physicians and any and all employees from all claims and liabilities whatsoever in law and in equity arising from disclosure and use of Media as authorized in this consent.

I understand that I may refuse to authorize the disclosure and use of any Media and that my refusal to consent will prevent its disclosure and use except solely in connection with healthcare services at KM Plastic Surgery, but such refusal will not affect the healthcare services that I receive from KM Plastic Surgery. I understand that I have the right to revoke this authorization in writing at any time, but I further understand that revocation will not apply to or cause the retraction of previously published, disclosed or used Media.

**By signing below, I acknowledge and certify that I have read, understood and agreed to the terms of this consent, and that I may request a copy of this document.**

Print Name: _____

Patient Signature: _____ Date: _____

If signed by person other than patient, please indicate relationship: _____

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# Financial Policies

Welcome to our office. Thank you for choosing KM Plastic Surgery and entrusting us with your care. This is information about our financial and billing practices.

- Payment for consultation and services are due at the time of service.
- We accept cash, personal checks, and credit cards. We also accept CareCredit ($250 minimum purchase required).

**If you are having a surgical procedure, a <u>non-refundable</u> deposit of $500 is due to secure your procedure date. The deposit will be applied toward your procedure balance. In the event surgery needs to be cancelled or rescheduled, the deposit will be forfeited, and a new deposit will be necessary to reschedule.**

- Payment for procedures/surgical services are due at least 14 days prior to service date.
- Your surgical quote does not include the cost of: Laboratory, Pathology, or prescription medications.
- Your surgical quote includes 3 post-op visits. Subsequent visits will be subject to an office fee.

Administrative Fees:

- $25 for appointment cancellations less than 48 hours' notice.
- $25 Insufficient Funds check return fee.
- $25 Statement fee for balances over 30 days
- $50 Admin Fee for processing FMLA/Disability forms.
- Balances over 120 days sent to Valley Empire Collections

**<u>Statement of Financial Responsibility:</u>**

I understand I am personally responsible for fees I have incurred. I have read and understand the financial policies. I agree to pay for services and fees as described above.

_____ _____

Patient Name Date

_____

Patient Signature

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# PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, _____, the undersigned patient, acknowledge I understand and agree that:

**KM Plastic Surgery** ("KMPS") is non-participating provider with Medicare/Medicaid.

I am covered by: Medicare ☐ Medicaid ☐
I am covered by another insurance Company ☐
I do not have medical insurance ☐

The health plan that covers me could include benefits for some or all the services provided by **KMPS**.

I understand that **KMPS** will NOT submit a claim to insurance for procedures/services I have requested**.**

By my informed election to self-pay for services, any payments I make to **KMPS** will not be credited toward satisfying any deductible I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.

I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

I have freely chosen to self-pay for services after having asked **KMPS** about payment options and having carefully considered my options.

Patient: _____ Date: _____

Signature of Patient or responsible party if patient Is a minor.

_____ _____

Printed Name of Patient or Responsible Party | Relationship to Patient