Kai Morimoto M.D.
PLASTIC SURGEON

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 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 Dr. Kai Morimoto MD and myself.

Signature: _____ **Date:** _____

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KAI MORIMOTO MD, PLLC

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 (ex. COPD, Diabetes, Asthma etc.):

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

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	Hay Fever/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

Smoking? ☐Never ☐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 _____**

Kai Morimoto MD PLLC

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 Dr. Kai Morimoto. 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.

KAI MORIMOTO MD, PLLC

COMMUNICATION CONSENT AND AUTHORIZATIONS

*Please initial the information you wish to authorize.

____ I give my consent for Dr. Kai Morimoto MD, PLLC 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 Dr. Kai Morimoto MD, PLLC or staff to **PHONE** me at my work.

____ I give my permission for Dr. Kai Morimoto MD, PLLC or staff to **TEXT** me.

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

____ I give my permission for Dr. Kai Morimoto MD, PLLC 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 Dr. Kai Morimoto MD, PLLC office.

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

Print Name: _____

Patient Signature: _____ Date: _____

KAI MORIMOTO MD, PLLC

PHOTO AND VIDEO CONSENT AND AUTHORIZATION

Agreement to capture, disclosure and use of still photos, moving video and computer images.

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 Kai Morimoto MD, PLLC patients.

□ **Yes** □ **No** – Publication on the Kai Morimoto MD, PLLC 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 Kai Morimoto MD, PLLC and may be retained for the purposes and uses approved in this consent. I understand that Kai Morimoto MD, PLLC 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 Kai Morimoto MD, PLLC 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 Kai Morimoto MD, PLLC, but such refusal will not affect the healthcare services that I receive from Kai Morimoto MD, PLLC. 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 Dr. Morimoto 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 non-refundable deposit of $500 is due to secure your procedure date. The deposit is applied toward your procedure fee with Dr. Morimoto.

- 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

Statement of Financial Responsibility:

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:

1. **Kai Morimoto MD PLLC** ("KMPS") is only a participating provider with Medicare/Medicaid.

2. I am covered by Medicare/Medicaid ☐
   I am covered by another insurance Company ☐
   I do not have medical insurance ☐

3. The health plan under which I am covered could include benefits for some or all the services provided by **KMPS**.

4. Despite the above, I do not wish **KMPS** to submit a claim to insurance for services provided to me**.**

5. By 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.

6. 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.

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

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

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient