REGISTRATION

La Mer Integrative & Behavioral Medical Group

Date: _____

Last Name: _____ **First Name**: _____ **MI**: _____

Date of Birth: _____ **Gender**: M_____F_____ **SSN**: _____

Weight: _____ **Height**: _____ **Marital Status** (Circle One): Married/ Single/ Other

Employment Status (Circle One): Employed/ Student/ Retired **Preferred Language**: _____

Current Smoker? : Y or N **Former Smoker?** Y or N **Frequency** (how many a day): _____

Race: _____ **Ethnicity**: _____ **Religion**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: (_____) _____-_____ **Cell Phone**: (____) _____-_____

Work Phone: (____) _____-_____ **Ext**. _____ **Preferred Phone**: _____

Email: _____

Advanced Directive Type (Circle One): No Advance Directive/ Living Will/ Durable Power of Attorney/ Do Not Resuscitate

Employer Name: _____ **Employer Phone**: (____) _____-_____

PRIMARY INSURANCE COMPANY _____

Insurance ID/Subscriber # _____ Group: _____

Patient's Relationship to subscriber: Self _____ Spouse _____

SECONDARY INSURANCE COMPANY _____

Insurance ID/Subscriber # _____ Group: _____

Patient's Relationship to subscriber: Self _____ Spouse _____

REFERRED BY _____**Primary Dr.**_____

EMERGENCY CONTACT: _____ **Relationship to Patient**: _____

Home Phone: (____) ____-_____ **Cell Phone:** (____) ____-_____

REGISTRATION

La Mer Integrative & Behavioral Medical Group

La Mer Integrative & Behavioral Medical Group bills insurance as a courtesy to our patients. The patient is responsible for all charges incurred, unless other arrangements are made in advance.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on the document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim.

I _____hereby authorize_____

Name of insured / patient Insurance Company

To pay and hereby assign directly to **La Mer Integrative & Behavioral Medical Group**

All benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that my insurance benefits, when received by and paid to La Mer Integrative & Behavioral Medical Group will be credited to my account, in accordance with the above said assignment.

X X_____ Date _____

Authorized Signature of Subscriber

REGISTRATION

La Mer Integrative & Behavioral Medical Group

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: LA MER INTEGRATIVE & BEHAVIORAL MEDICAL GROUP
1901 Outlet Center Drive, Suite 220
Oxnard, CA 93036
Ph: (805) 388-8330 Fax: (805) 388-8030

To Release to: _____
_____
_____
_____

The information (circle below) for the purpose:

A. Psychiatric Diagnostic

B. Non-psychiatric, medical diagnostic and treatment records including, but not limited to in-patient, outpatient, lab and x-ray reports.

C. All of the above

D. Other: _____

I also consent to the specific release of the following records:

Drug/ Alcohol/ Substance Abuse _____ (initial) HIV Diagnosis/ Treatment _____ (initial)
Psychiatric/ Mental Health _____ (initial) Genetic Information _____ (initial)

I certify that: ( ) I am there person described in this information
( ) I am the parent, legal guardian, or legal representative of the person described in this information

This is a: ( ) One time consent, extending only until _____, 20_____
( ) Continuing consent.

I understand that I have the right to inspect and copy any information authorized for release by me. I also have the right to revoke consent in writing at any time.

My signature below attests that I have been apprised of the possible problems of waiving the privilege of privacy.

_____ _____
Name of Patient (print) Date of Birth

_____ _____
Signature Date

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_____ _____
Signature Date

REGISTRATION

La Mer Integrative & Behavioral Medical Group

HIPAA Notice of Privacy Practices
Acknowledgement Form
La Mer Integrative & Behavioral Medical Group
Jeanne Hesse, Privacy Officer 805-388-8330

I hereby acknowledge that I have access to a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available at the front desk upon request.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship: guardian or conservator of an incompetent patient.

Your Name:_____ Patient Name:_____

As health care professionals, we are mandated to report Elder Abuse and Domestic Violence.

FINANCIAL RESPONSIBILITY STATEMENT

You are financially responsible for your treatment. Payment is due at the time of service, unless previous arrangements have been made. All unpaid deductibles & patient co-pays must be paid at the time of service.

Your insurance benefits may help you meet your financial responsibility. We will be happy to assist you in processing your insurance claims for payment**. Your insurance benefits are based on contracts between you and your insurance company.** Some services may not be reimbursed through your insurance policy or may only be partly reimbursed by insurance. In all cases, you are responsible for the total allowable fee for the service.

There is a $ 15.00 fee for each form completed by La Mer Integrative & Behavioral Medical Group on your behalf. (Other than medical insurance claim forms and state disability forms.) There is a fee for the copying of your medical records.

A charge is made for missed appointments, regardless of the reason, if you do not notify La Mer 24 hours in advance of your appointment. You are personally responsible for your appointment. You are personally responsible for the missed appointment fee, as this fee is not billed to or reimbursed by insurance.

There is a $ 15.00 fee for **returned checks**.

We encourage you to contact the billing department regarding your account, financial problems or questions about your insurance.

Signature: _____

Date: _____

REGISTRATION

La Mer Integrative & Behavioral Medical Group

PROBLEM LIST

Please rate how you have been feeling during the past week including today.

KEY: 0 - NONE 1 - MILD 2 - MODERATE 3 - MARKED 4 - SEVERE

1. Depressed sad	0	1	2	3	4	26. I move slower sit in one place for long periods	0	1	2	3	4
2. I am so depressed that not even good new would cheer me up	0	1	2	3	4	27. I'm so restless I can't sit still or relax	0	1	2	3	4
3. Angry, Irritable, hostile	0	1	2	3	4	28. Thoughts slowed down	0	1	2	3	4
4. Decreased self esteem or self confidence low thoughts about my self	0	1	2	3	4	29. Racing Thoughts	0	1	2	3	4
5. Guilt Feelings, feeling like a burden family or society	0	1	2	3	4	30. Mood worse in morning	0	1	2	3	4
6. Hopelessness, things will not get better	0	1	2	3	4	31. Mood worse in evening	0	1	2	3	4
7. Helplessness I can change things	0	1	2	3	4	32. My mood change very rapidly	0	1	2	3	4
8. Trouble falling asleep	0	1	2	3	4	33. Thoughts of suicide wishing I were dead or not caring if I live	0	1	2	3	4
9. Waking up in the middle of the night	0	1	2	3	4	34. Intent to kill myself	0	1	2	3	4
10. Waking in the morning 1 - 2 hours before I need to	0	1	2	3	4	35. Wanting to hurt or punish myself (not suicide)	0	1	2	3	4
11. Sleeping more than usual	0	1	2	3	4	36. Anxious, nervous, worried	0	1	2	3	4
12. Drowsy during the day	0	1	2	3	4	37. Psychical anxiety symptoms like my heart beating oddly being short of breath tremor, butterflies in my stomach frequent urination sweating, muscle tension, numbness in my hands or feet	0	1	2	3	4
13. Fatigue low energy hard to get going	0	1	2	3	4	38. So afraid of certain things or situations that I avoid them	0	1	2	3	4
14. Decreased appetite	0	1	2	3	4	39. Sudden severe feelings that something terrible is going to happen like I will die, go crazy or pass out	0	1	2	3	4
15. Increased appetite	0	1	2	3	4	40. Hearing voices or seeing things that are not there	0	1	2	3	4
16. Decreased weight	0	1	2	3	4	41. Believing things that others do not believe	0	1	2	3	4
17. Increased weight	0	1	2	3	4	42. Feeling suspicious of others that others want to hurt me or are against me	0	1	2	3	4
18. Decreased sexual interest	0	1	2	3	4	43. Unpleasant unrealistic thoughts go over and over my mind an I cant's stop them	0	1	2	3	4
19. Increased Sexual interest	0	1	2	3	4	44. Feeling compelled to do senseless things over and over	0	1	2	3	4
20. Decreased interest in usual actives	0	1	2	3	4	45. Feeling I am some other person or am outside my body	0	1	2	3	4
21. Decreased involvement in usual activities withdrawn	0	1	2	3	4	46. Feeling things are not real like in a fog or dream world	0	1	2	3	4
22. Decreased pleasure or less enjoyment of usual activities	0	1	2	3	4	47. Worried about my physical health	0	1	2	3	4
23. Decreased memory	0	1	2	3	4	48. Feeling rejected by other	0	1	2	3	4
24. Decreased concentration	0	1	2	3	4	49. Unable to control my impulses	0	1	2	3	4
25. Indecisiveness unable to make decisions	0	1	2	3	4	50. Drinking alcohol or using recreational drugs	0	1	2	3	4

NAME: _____ DATE: _____