REGISTRATION

La Mer Holistic Medicine

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 _____

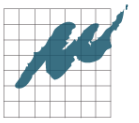
REFERRED BY _____

Primary Dr._____ **PCP Phone#: (____) ____ - _____**

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

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

1901 Outlet Center Drive, Suite 220, Oxnard, CA 93036 (805) 388-8330



REGISTRATION

La Mer Holistic Medicine

La Mer Holistic Medicine 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 Holistic Medicine**

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 Holistic Medicine will be credited to my account, in accordance with the above said assignment.

X X_____ Date _____

Authorized Signature of Subscriber

1901 Outlet Center Drive, Suite 220, Oxnard, CA 93036 (805) 388-8330

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: LA MER HOLISTIC MEDICINE
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 the person described in this information
( ) I am the parent, legal guardian, or legal representative of the person described in this information

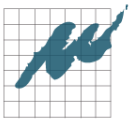
This is a: ( ) One time consent, extending only until _____, 20_____
( ) Continuing consent.

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



REGISTRATION
La Mer Holistic Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: _____
_____
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To Release to: LA MER HOLISTIC MEDICINE
1901 Outlet Center Drive, Suite 220
Oxnard, CA 93036
Ph: (805) 388-8330 Fax: (805) 388-8030

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Name of Patient (print) Date of Birth

_____ _____
Signature Date

HIPAA Notice of Privacy Practices
Acknowledgement Form
La Mer Holistic Medicine
Keri Winget, Privacy Official 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 $ 25.00 fee for each form completed by La Mer Holistic Medicine 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: _____