PATIENT INTRODUCTION

— PATIENT INFORMATION —

Todays Date | Family Physician | Physicians Phone Number | Referred By

Patient's Last Name | First | Middle | Home Phone Number

Residence Address | Apt. No. | City | State | Zip

Social Security Number | Date of birth | Marital Status | Drivers License Number

Employer/School | Address | City/State | Phone Number

Spouse's Name | Employer | City/State | Phone Number

Nearest Friend or Relative | Relationship to Patient | Phone Number

— RESPONSIBLE PARTY —

Complete this section only if someone **other** than the identified patient is responsible for payment.

Last Name | First | Middle | Home Phone Number

Residence Address | Apt. No. | City | State | Zip

Social Security Number | Date of birth | Marital Status | Drivers License Number

Employer | Address | City/State | Phone Number

Spouse's Name | Employer | City/State | Occupation | Phone Number

Nearest Friend or Relative | Relationship to Patient | Phone Number

VENTURA PSYCHIATRIC MEDICAL GROUP PAYMENT POLICY

1. **PAYMENT** Payment is due at time of service. Cash, Check or Visa/Mastercard.
2. **LATE PAYMENT FEE** A 1½ percent per month fee shall be assessed on all accounts more than 60 days past due. A 1½ percent rate per month is based on an annual interest rate of 18 percent.
3. **CHARGE FOR LATE CANCELLATIONS AND MISSED APPOINTMENTS** 24 hour notice is required to cancel or reschedule an appointment without being charged. Monday appointments may be cancelled by leaving a message with our answering service over the weekend, (805) 659-1333.
4. **DEFAULT** The prevailing party shall be entitled to all costs incurred to enforce payment of default accounts including, but not limited to, collection agency fees, filing fees, attorney's fees, and court costs.

I have completed this form and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage I am responsible for payment of service. I have read and agree to the terms of this Payment Policy.

Date | Signature of Person Responsible for Payment

NOTICE

Rafael Canton, MD, Colleen Copelan, MD and Ronald C Thurston, MD are California-licensed physicians with additional board certification by the American Board of Psychiatry & Neurology

In California, medical doctors are licensed and regulated by the California Board of Medicine
800 633 2322
www.mbc.ca.gov

Patient (or representative)_____Date_____

Compliance with CCR 1355.4 and Section 680.5 Business & Professions Code

RAFAEL CANTON,MD, COLLEEN COPELAN, MD & RONALD C. THURSTON, MD

970 South Petit Ave, Suite A
Ventura, CA 93004
Acknowledgment of Receipt of
Notice of Privacy Practices

Patient Name: _____ **Birth date**: _____
Maiden or other name (if applicable):_____

I acknowledge that I have received a copy of the Notice of Privacy Practices from Rafael Canton, MD, Colleen Copelan, MD & Ronald C. Thurston, MD, effective April 14, 2003.

Signature (patient or authorized representative):_____

Date: _____

Relationship/authority (if signed by authorized representative): _____

HEALTH MEMBER ORGANIZATION BENEFITS NOTIFICATION

Your Plan benefits will not apply in all circumstances. You are responsible for full payment, at our usual and customary fees, for services not covered by your plan benefits. Please read carefully.

A. **Your plan benefits must be pre-authorized.** Benefits will not apply unless;

1.) We have, at time of the first visit,
   a. A REFERRAL signed by your primary care doctor.
   b. A PRIOR AUTHORIZATION FOR BENEFITS.

2.) We have, at the time of all subsequent visits, a PRIOR AUTHORIZATION FOR BENEFITS signed by the review coordinator covering the prescribed treatment services.

If these benefit review procedures are not completed by the time of service, you are responsible for full payment. If benefits are subsequently paid by your plan, you will receive a refund deducting only the required plan co-payment. We will do our part in requesting benefit authorization but the benefit decision is made by your Plan reviewer on the basis of your specific Plan agreement.

B. **Your Plan does not cover all services.** Your Plan covers mental health services only for certain defined crisis interventions, acute mental health problems, and short-term conditions. You may need, and your doctor may recommend, treatment services that are not covered by your Plan. In such situations, you are personally responsible for the cost of all non-covered treatment services.

C. **You must be an eligible Plan member for benefits to apply.** Pre-authorization of benefits is void if you are not eligible at the time of service. In such case you are personally responsible for the cost of treatment services.

If you have any questions about benefits and benefit authorization procedures, please call your Health Member Organization.

AGREEMENT TO PAY FULL COST OF TREATMENT SERVICES NOT AUTHORIZED OR NOT COVERED BY PLAN BENEFITS

I have read the above description of benefit procedures and benefit limitations and I am familiar with my Plan benefits. I agree to accept full financial responsibility for all treatment services rendered at Ventura Psychiatric Medical Group not authorized by my Plan agreement.

X Signed: _____ Date: _____

Ventura Psychiatric Medical Group
INSURANCE INFORMATION

Patient's Name (Last, First, Middle Initial) _____ Today's Date _____

We will bill your insurance carrier if you provide the necessary information. But please remember:

Your insurance carrier is responsible to **you**, not us. We have no power to make your insurance carrier pay your bill. There is a late payment charge on all accounts more than 60 days past due.

Please list your Insurance Carriers in the order in which you want them billed:

1. Primary Insurance Carrier (Billed First)

Insured Person's Name (Last, First, Middle) _____ Marital Status _____ Date of birth _____

Insured Person's Address _____ Employer _____ Social Security Number _____

Insurance Company Name _____ Street Address _____

City _____ State _____ Zip _____ Telephone Number _____

Identification No. _____ Policy Number _____ Relationship to pati[illegible] No. _____

2. Secondary Insurance Carrier (Billed Second)

Insured Person's Name (Last, First, Middle) _____ Marital Status _____ Date of birth _____

Insured Person's Address _____ Employer _____ Social Security Number _____

Insurance Company Name _____ Street Address _____

City _____ State _____ Zip _____ Telephone Number _____

Identification No. _____ Policy Number _____ Relationship to patient _____

Does your insurance company require you to make a copayment? ☐ YES ☐ NO

Authorization to Release Information: I hereby authorize my therapist at Ventura Psychiatric Medical Group to release information required to process my insurance claim.

_____ _____

Patient/Guardian (if Patient is a minor) Signature Date

Assignment: I authorize payment of medical benefits to the provider for diagnostic and treatment service.

_____ _____

Insured's Signature Date

Do you want us to do your insurance billing? ☐ YES ☐ NO

******* REVIEW OF SYSTEMS QUESTIONNAIRE *******

PLEASE *CIRCLE* ALL ITEMS THAT ARE--OR HAVE BEEN--A PROBLEM

DATE_____PATIENT'S NAME_____DOB_____

CONSTITUTIONAL Change in appetite or weight, or sleep. Need better diet. Need more exercise. Weakness, fatigue, fever, night sweats. Recent falls. Recent injuries.

SKIN: Itching, rashes, streaks, lumps, cuts, sores, dryness, thickening of skin. Changes in color. Change in a mole. Change in hair or nails, hair loss.

EYES: Change in vision. Eye pain. Blurred, hazy or double vision, blind spots, flashing lights, or "floaters." Excessive tearing. Headache. Wear glasses or contact lenses?

EAR, NOSE & THROAT: Hearing loss. Ringing. Dizziness. Ear pain or discharge. Sinus or nose pain, congestion or discharge. Nose bleeds. Bleeding gums. Sore throat or pain when swallowing. "Hay fever" or allergies. Dental problems, dentures.

RESPIRATORY: Hard to breathe Cough, congestion, coughing up mucus or blood. Shortness of breath. Poor stamina. Frequent bouts of bronchitis. Wheezing.

CARDIOVASCULAR: Chest pain, short of breath. Trouble breathing when lying down. Poor stamina. Heart skipping or racing. Leg pain when walking. Swollen legs or feet. Light-headed. Losing consciousness. Murmurs. Blood pressure. Rheumatic fever.

GASTROINTESTINAL: Difficult or painful swallowing. "Heartburn." Nausea or vomiting, vomiting blood or "coffee-grounds." Food intolerance, loss of appetite or weight. Indigestion, bloating, abdominal pain or cramping, diarrhea or constipation. Pain with bowel movement. Bloody or tarry stool. Jaundice or hepatitis.

GENITOURINARY: Pain or burning on urination. Urgency or losing control of urine. Trouble starting to urinate, decreased force of stream, dribbling. Frequent urination, frequently up at night to urinate. Kidney stones. Genital pain, lumps, sores or discharge. Breast pain, soreness, lumps, or discharge. Sexual problems. Concern about sexually transmitted infections.

Women: Age at onset of menstrual periods___. Irregular, scant or excessive or prolonged bleeding. Premenstrual boating or moodiness. First day of last period____. Number of pregnancies___. Number of births___. Age at menopause____. Menopausal troubles: hot flashes, night sweats, decreased sex drive, depression, weight gain. Pain on intercourse. Use birth control: yes/no. Last Pap & results_____.

MUSCULOSKELETAL: Back or neck pain or stiffness. Painful or discolored extremities. Muscle pain, cramps, soreness. Joint pain or swelling. Decreased function or range of motion. Arthritis.

NEUROLOGICAL: Fits, faints, headache. Trouble speaking or slurred speech. Weakness anywhere. Balance problems. Dizziness. Shakiness or tremor. Numbness, "pins and needles" or burning sensation. Loss of bladder or bowel control. Forgetfulness or trouble remembering words or events. Change in personality. Change in smell, vision, hearing, or taste. History head injury or loss of consciousness. Seizures/convulsions. Stroke or "mini-stroke" (TIA).

PSYCHIATRIC: Anxiety or excessive worry. Moodiness or irritability. Depression, loss of interest, enjoyment or ambition. Social withdrawal. Thoughts of dying. History or risk of self-harm. Surges of energy, excitement, and ambition with decreased need for sleep. Bouts of heightened sexual drive, spending "binges," gambling or thrill-seeking or reckless behavior. Abnormal or unwanted thoughts. Decline in work or school performance or attendance.

ENDOCRINE: Usually cold, tired, or slow; less energy and motivation, dry skin, hoarse voice, thinning hair. Usually warm, jittery, sweaty; heart palpitations, tremors, "mood swings," diarrhea, weight loss, visual disturbances. Increased hunger but losing weight, increased thirst and urinating larger quantities. Light-headedness, low blood pressure, fatigue, decreased motivation, change in mood or personality, craving for salt, or darkening of skin. Weight gain in face and trunk, low energy, "mood swings," depression, sweating, thinning skin with stretch lines, brittle hair loss, decreased sexual interest and function. Increased facial hair. Change in ring size or shoe size. Thyroid problem. Diabetes.

HEMATOLOGIC/LYMPHATIC: Fatigue. Easy bruising, multiple pin-point-size bruises, bleeding gums or prolonged bleeding. Swollen "glands" (lymph nodes). Transfusion reaction.

ALLERGIC/IMMUNOLOGIC: Any episode of sudden, intense difficulty breathing and choking after a bee sting, eating shellfish or contact with other such triggers. Any episode of Itching or rash or swollen/painful glands in groin, armpit or neck following contact or exposure to certain materials, foods, or animals. Episodes of sinus congestion, sneezing, runny nose, itchy/teary eyes. Anaphylaxis

****

Reviewed with patient by_____MD, on_____