Dear Patient:

Welcome to our medical practice. We pride ourselves on providing you with the best medical care possible.

Our relationship with you is important to us. Please complete all forms carefully and completely. In order to avoid any misunderstanding, please read our office policies. If you have any questions, our staff is happy to assist you.

- You are expected to pay your co-pay when you check in for your appointment. These amounts are not billable.
- We are happy to bill your insurance plan on your behalf as a courtesy. However, we may not be a “preferred provider” of your plan and may not know what amount your plan will pay. You can contact your insurance company for this information. **Payment is expected when services are rendered if we are not contracted with your insurance plan.**
- We will bill you for your balance after we receive the explanation of benefits from your insurance company if we are contracted with your plan. Payment for your portion is expected upon receipt of our statement.
- If we are contracted with your plan it is required that we collect in full all copayments, coinsurance and deductibles associated with your policy. We are unable to waive or discount copayments, coinsurances or deductibles that are your responsibility without violating our contact with your plan. **This includes Medicare**.
- It is imperative that you inform us of any changes to your address, phone number or insurance coverage prior to scheduling an appointment.
- There will be a $25.00 fee assessed for any and all checks returned from the bank for any reason.
- We require 24 hours notice for appointment cancellations. There is a fee charged for cancellations made without this notice.
- Multiple missed appointments may result in discharge from our practice.
- We accept cash, check, VISA, Mastercard and American Express.

I understand the financial policy of this office.

Patient Name_____________________________________ Date___________________

Signature _____________________________________

Relationship (if not patient) _______________________

Today's date:	Primary physician:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Apt #	Home phone #: ( )		
City:	State:	Zip Code:	Cell phone #: ( )		
Occupation:	Employer:		Employer phone #: ( )		

Marital status: (circle one) Married Single Divorced Widowed Name of Spouse:

Race: ___ Decline to state | Ethnicity: ___ Hispanic ___ Non-Hispanic ___ Decline to state

Preferred method of contact: ___Home phone ___Cell phone ___Work phone ___Email address:

Smoking status: Please check one: ___ Current smoker ___ Former smoker ___Never smoked | Preferred language:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Blue Cross	❑ Blue Shield	❑ Seaview	❑ Tricare

❑ Other: Specify:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. The undersigned hereby authorizes and consents to receiving medical/psychiatric/psychotherapy care and treatment by Lorna M. Barte, M.D., and Thomas Wright, Ph.D., MFT

Patient/Guardian signature *Date*

Authorization for Consent of Patient Treatment

Authorization for Consent to Treat a Minor

The undersigned hereby authorizes and consents to receiving medical / psychiatric / psychotherapy care and treatment by:

Lorna M. Barte, M.D. and Associates, A Behavioral Health Management Group, Inc.

and

Lorna M. Barte, M.D.; and/or Thomas Wright, PhD.

I understand that services are mental health in nature.

This authorization will remain in full force and effect until services are completed or cancelled by either party. A photocopy hereof shall be as valid as the original.

Patient name_________________________________ Birthdate____________________

Signature of responsible party____

Relationship (if not patient) ___________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
LORNA M. BARTE, M.D. AND ASSOCIATES A BEHAVIORAL HEALTH MANAGEMENT GROUP, INC.

1601 Carmen Drive, Suite 106
Camarillo, CA 93010
Kathleen Snow/Privacy Officer
805-389-8111

THE NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THS INFORMATION.

I hereby acknowledge that I have access to this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area. Copies of the current and any amended Notice of Privacy Practices are available at the front desk upon request.

Signed:______________________________ Date:____________________

Print Name:_________________________ Telephone:_______________
If not signed by the patient, please indicate:

Name of patient:_______________________________________
Relationship to patient:
___ Parent or guardian of minor patient
___ Guardian or conservator of an incompetent patient
___ Beneficiary or personal representative of deceased patient

Authorization and Assignment of Insurance Benefits

The undersigned hereby authorizes the release of health care information relating to all claims for benefits submitted on behalf of myself or my dependent by Lorna M. Barte, M.D. and Associates, A Behavioral Health Management Group, Inc., Nicole Montgomery, CNP and Thomas Wright, PhD. I understand that services are mental health in nature and may include information regarding psychotherapy.

I understand that I am personally responsible for all medical fees and that payment in full is due at the time services are rendered, unless previous arrangements have been made. Claims are submitted as a courtesy to me for my reimbursement and payment for services are in no way contingent upon insurance decisions and/or payment.

I assign directly to Lorna M. Barte, M.D. and Associates, A Behavioral Health Management Group Inc. or Thomas Wright, PhD or Nicole Montgomery, CNP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that if my insurance pays the medical group or clinician and I have also paid, I will be reimbursed the overpayment amount by the medical group or clinician.

Patient name_________________________________ Date___________________

Signature of responsible party____

Relationship (if not patient) __________________