BOWMAN
MEDICAL GROUP
INTEGRATIVE HEALTH CARE SPECIALISTS

CONTACT INFO

Name: _____ Date of Birth: _____ Age: _____

Today's Date _____ M☐ F☐ Sexual Orientation_____ Ethnicity_____

Social Security Number_____ Highest grade complete/ Degree_____

Address: _____

City: _____, California Zip: _____

Home : _____ Fax: _____

Cell : _____ Cell Phone Carrier for text messaging: _____

Email: _____

Who referred you to Bowman Medical Group?_____

❑ Married ❑ Single ❑ Partner ❑ Divorced ❑ Separated ❑ Widowed

Your occupation:_____

Who lives with you in your home?

Name	Relationship	Age	Occupation

REASON FOR VISIT

What specific problems/ concerns bring you in for an evaluation at this time?

_____

_____

_____

EMERGENCY CONTACT INFO

In case of emergency, please notify: _____

Relationship to client: _____ phone: _____

If client is a minor or dependent adult, please notify: _____

Relationship to client: _____ phone: _____

PHARMACY MEDICAL THERAPY

Pharmacy Name: _____ phone: _____

Primary Care Physician: _____ phone: _____

Therapist: _____phone: _____

Address: _____

INSURANCE

Carrier: _____ Phone: _____

Policy/Member Id Number: _____Group Number : _____

Insured's Name (if different from patient) _____ DOB:_____

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ALCOHOL USE	No	Yes	Drinks per sitting	INTOXICATION FREQUENCY			
				1x/week	2x/week	3x/week	4x/week +
Alcohol							

DRUG USE	No	Yes	How often?
Marijuana			
Cocaine			
Methamphetamines			
Sedatives			
Opiates			
Hallucinogens			
Stimulants			
Abuse of Prescription Medication			

IF YOU ANSWERED YES…

1. Has your substance use ever felt like a problem to you ❑**Yes** ❑**No**
2. Have you received drug or alcohol treatment before? ❑**Yes** ❑**No**
3. Have you ever participated in a 12-Step program for addiction? ❑**Yes** ❑**No**

FAMILY HISTORY	No	Yes	If yes, please explain
Does anyone in your family have a mental illness?			
Has anyone in your family ever attempted or committed suicide?			
Does anyone in your family have a substance abuse problem?			
Was there physical violence or any trauma related incidents in your family home?			
HOSPITALIZATION	**No**	**Yes**	**If yes, please explain**
Have you ever been hospitalized for a psychiatric illness?			
LEGAL ISSUES	**No**	**Yes**	**If yes, please explain**
Have you ever been arrested?			
Are you required by a court of law to receive counseling as part of an ongoing legal proceeding?			

How well you are doing on your job:

0 Not Working | 1 | 2 Cannot Function | 3 | 4 Serious Problems | 5 Moderate Problem | 6 | 7 Mild Problems | 8 | 9 No Problems

How well you are doing in your marital/significant other relationship:

0 Not Applicable | 1 | 2 Cannot Function | 3 | 4 Serious Problems | 5 Moderate Problem | 6 | 7 Mild Problems | 8 | 9 No Problems

How well you are doing in your family relationships:

0 Not Applicable | 1 | 2 Cannot Function | 3 | 4 Serious Problems | 5 Moderate Problem | 6 | 7 Mild Problems | 8 | 9 No Problems

How well you are doing in relationships with people outside your family:

0 Not Applicable | 1 | 2 Cannot Function | 3 | 4 Serious Problems | 5 Moderate Problem | 6 | 7 Mild Problems | 8 | 9 No Problems

Please rate your current physical health:

0 Very Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 Excellent

Please rate your general happiness and well-being:

0 Very Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 Excellent

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In the PAST YEAR have you experienced any of the events listed below?

	Yes	No
Death of spouse/ partner		
Divorce		
Marital separation		
Legal problems		
Death of close family member (except spouse)		
Major personal injury or illness		
Marriage		
Loss of job		
Retirement		
Illness of family member		
Financial problems		
Physical attack		
Pregnancy		
Sex difficulties		
Death of close friend		
Serious marital problems		
Son or daughter leaving home		
Trouble with in-laws		
Trouble with boss		
Change in residence		
Change in schools		
Change in job or job responsibilities		
Trouble with adults		
Trouble with children		
Caring for seriously ill/ disabled relative/ friend		

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Symptom & Severity (if applicable)	Mild	Moderate	Severe	For how long?
Depressed Mood, Hopelessness				
Social Isolation, Loneliness				
Suicidal Thoughts				
Bereavement or Feelings of Loss				
Excessive Sleeping				
Not sleeping enough				
Anxiety, Frequent Worry or Tension				
Panic Attacks				
Feelings of Guilt				
Anger, Hostility				
Violent Acts				
Risk Taking Behaviors				
Compulsive Behaviors				
Racing Thoughts				
Obsessive Thoughts				
Strange, Unusual Thoughts				
Memory Problems				
Problems Concentrating				
Gender Concerns				
Sexual Problems				
Weight Gain or Loss (Circle One)				
Restricting, Bingeing or Purging of Food				
Communication Problems				
Physical Disability				
Sex Drive				
Energy Level				
Nervousness				

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Office Policies

Payment Policies (please initial each):

- Patient agrees to pay for all portions of services due in full at the time services are provided by our office. You may pay by cash, check or credit card. We accept all major credit cards. _____

- If you would like to use your Cigna insurance plan, please provide your insurance card to the front office staff along with valid ID. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier had not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. _____

- If you have any other PPO insurance plan and would like to use your **out of network benefits**, you must pay the full amount for your appointment at the time of service. We will provide a superbill for the services rendered for you to submit to your insurance company for reimbursement. _____

- Any medication adjustments made outside of an office visit (phone or email) will be billed to the patient's insurance company. Typically, no additional out-of-pocket payments will be required from the patient. _____

- There is a fee for any disability paperwork, letters, and legal paperwork requested that ranges from $25-$100. This fee cannot be billed to an insurance company and is your responsibility. _____

- For returned checks we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. We may refuse checks as a form of payment after 2 returned checks on account. _____

- If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees. _____

- There is a $30.00 fee to copy medical records. This fee cannot be billed to an insurance company and is your responsibility. _____

Appointment Cancellations:

- To avoid being charged, at least 24 hours notice must be given to the office to cancel an appointment. If the office staff is unavailable to answer your call, a voicemail message must be left in order to ensure receipt of your cancellation in a timely manner. _____

- A cancelled appointment with less than 24 hours notice will result in a fee equivalent to the full amount of your appointment. This fee cannot be billed to an insurance company and is your responsibility. _____

Emergencies/ After Hours:

- In the event of an emergency call 911. If the matter is urgent, call the office's main number (310-276-4003). During normal business hours, the receptionist will set up an urgent appointment. _____

Parking:

- ❖ We do not validate for valet parking in the building. _____
- ❖ Metered parking is located across the street on S. Santa Monica Blvd. _____

Your signature below indicates that you have read, initialed and understood this information. Thank You.

_____ _____

Signature Date

_____

Print Name