New Patient Form

Patient Information

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Patient Preferred Name**

Address | **Address 2** | **City** | **State** | **Zip**

Primary Phone | **Cell Phone** | **Email Address**

Date of Birth | **Sex** Male Female Other | **Social Security Number**

Explain

Marital Status

Single Married Widowed Divorced

Occupation | **Employment Type** Full - Time Part - Time | **Employer Name** | **Work Phone**

Work Address | **Address 2** | **City** | **State** | **Zip**

Name of Spouse/Parent

Occupation

Employed by

Work Address | **Address 2** | **City** | **State** | **Zip**

Referred by:

Guarantor’s Information

Guarantor’s Name | **Guarantor’s Social Security Number** | **Guarantor’s Date of Birth**

Guarantor’s Employer | **Guarantor’s Address** | **Guarantor’s Phone**

Guarantor’s Cell/Work

I authorize Beaumont Family Practice’s office to give test results to my spouse.

Yes No

History

Patient

Responsible Party

Provider Request

☐ Jay C. Proctor III, MD ☐ Jae Doyle, NP-C ☐ Amber N. Fling, FNP-C ☐ Bud Church, PA ☐ William Kujawski RN, MSN, FMP, BC ☐ Stacey Walker, FNP-C

Present Illnesses (list below your primary ailments today)

DURATION

Past History

Date

List All Medications You Are Now Taking (Please Include Over-the-counter Vitamins, Herbs, Pain Relievers And Illegal Drugs)

List All Medications You Are Allergic to

Family History

Spouse

Father

Mother

Sisters

Sisters

Brothers

Brothers

Do you have a family history of any of the following diseases?

☐ Diabetes ☐ TB (Tuberculosis) ☐ Heart trouble ☐ High blood pressure ☐ Epilepsy ☐ Cancer ☐ Arthritis ☐ Gout

EENT:

Do you have any type of eye disease? Yes No

Do you wear glasses? Yes No

Do you have any type of ear disease? Yes No

Do you have have fever or sinus trouble? Yes No

Do you have frequent sore throats? Yes No

Chest

Do you smoke? Yes No

If so, how many packs per day?

Have you ever had chronic chest condition such as asthma, bronchitis, etc.?
Yes No

CARDIOVASCULAR:

Has a doctor ever said you have heart trouble?
Yes No

Has a doctor ever said you have high blood pressure?
Yes No

Have you ever had rheumatic fever? Yes No

Do you get tired easily or get “short of breath”?
Yes No

Have you ever been told you have a heart murmur?
Yes No

Do you have occasional chest pain? Yes No

Do your ankles swell at times? Yes No

Do you have chest pain after eating or exercise?
Yes No

GI

Do you often suffer from upset stomach?
Yes No

Have you ever been treated for ulcers? Yes No

Do you drink alcoholic beverages? Yes No

How Much?

Have your bowel habits changed in the past year?
Yes No

GU

Have you ever had kidney diseases or infection?
Yes No

Do you have to get up at night to urinate?
Yes No

METABOLIC

Have you had any significant weight gain or loss in the last year?
Yes No

Do you have sugar diabetes? Yes No

Do you seem to have excessive thirst or excessive urine output?
Yes No

Do you have thyroid trouble? Yes No

JOINTS

Are your joints often painful or swollen? Yes No

NERVES

Did you ever have a nervous breakdown?
Yes No

Do you seem to be tense and nervous all of the time?
Yes No

Do you sleep well at night? Yes No

FOR WOMEN ONLY

How many children do you have?

Age period started

Have you had a miscarriage?

Yes No

Do your periods come at regular intervals?

Yes No

Taking Birth Control Pills?

Yes No

Name of pills

Do you have an IUD?

Yes No

If so, how long?

If Yes, Please Indicate The Condition Being Treated.

When was your last pregnancy?

When was your last normal menstrual period?

Any Other Medical Conditions Not Listed Above?

I, , have reviewed the information on this medical history form and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor. I authorize the insurance company indicated on this form to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature Of Responsible Party

Acknowledgment of Review of Notice of Privacy Practices

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority

ASSIGNMENT OF BENEFITS FORM

ASSIGNMENT OF BENEFITS FORM

Practice Name: Beaumont Family Practice Associates

Address: 6450 Folsom Drive, Beaumont, TX 77706

Phone: (409)835-0524

Date

Patient Name

Employer

Claim Group Name/No

ID#

I hereby instruct and direct:

Insurance Company

to pay my medical claims by check made out and mailed to:

Beaumont Family Practice Associates

6450 Folsom Drive

Beaumont, TX 77706

OR

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make payment by assigning benefits directly to me and addressing payment to the temporary address as follows:

(Patient or Guarantor's Name)

c/o Beaumont Family Practice Associates

6450 Folsom Drive

Beaumont, Texas 77706

For the professional or healthcare expense benefits allowable and otherwise payable me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balances of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date

Signature of patient/guarantor/policyholder

Signature of Witness

Medical Release Form

Patient Information

Patient Name

Date of Birth

Requested From

Name of Provider

Provider Contact

Address

Send Information To

Name of Recipient

Address

Information to be disclosed

I authorize the release of the following health information:

- [ ] **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.**
- [ ] **Only the certain records or types of health information as listed below**

Large Text Field

Authorization

I, , authorize to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information electronically or by fax to .

Patient Name

Patient Signature

Date

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian

Legal Relationship **Date**

Medical Consent Form

I, ,knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Dr. Jay C. Proctor III, his assistants or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Jay C. Proctor III, his assistants or his designee.

Patient Name

Signature

Date

AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name

Name of Patient or Legally Authorized Representative

I, , acting on behalf of , hereby authorize the release of information as indicated.

MY HEALTH CARE INFORMATION

☐ **I authorize disclosure of health care information (related to my medical history, diagnosis, or treatment or prognosis) to all inquirers or only to the following people or entities (for example, family, friends, employer, insurance companies, clergy, etc.)**

List First & Last Name:

LIMITED HEALTH CARE INFORMATION

☐ **I wish to limit disclosure of only certain kinds of health care information (related to my medical history, diagnosis, treatment or prognosis) to the following people or entities.**

List Name & Information to be released

List Name & Information to be released

List Name & Information to be released

List Name & Information to be released

☐ **I do not authorize release of any information regarding my admission or treatment. I wish to be a “no information” patient.**

Signature

Date

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Terry Dixson, Privacy Officer

6450 Folsom Drive

Beaumont, TX 77706

Fax (409)835-0632, Phone (409)835-0524

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions so a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage as other providers the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the patient and may no longer be protected by federal HIPAA privacy regulations.

PATIENT QUESTIONNAIRE

Patient Name

Date of Birth

What is your primary language?

Are you bilingual?

Yes No

What is your race? American Indian, Asian, Alaska native, Natural Hawaiian, Black/African American, White, Hispanic, other?

Please present receptionist with Driver's License and Insurance Cards

Driver's License #

Primary Insurance Co Name:

Secondary Insurance (if any):

Please be advised when establishing at BFPA with a Nurse Practitioner or Physician Assistant, you will **ONLY** be able to see that Nurse Practitioner or Physician Assistant. Dr. Proctor only sees patients who have **INITIALLY ESTABLISHED** with him.

- [ ] **I have read and understand the above statement.**

Signature

Date

WRITTEN NOTIFICATION OF ALTERNATIVE SITES FOR IMAGING

Patient Name

According to CMS and Texas Law we must notify you that you have the right to choose an alternative site for your testing other than this office. You may choose from the following alternative sites: Beaumont MRI, Diagnostic Health, ODC, Baptist Hospital, or St. Elizabeth Hospital. If you wish to use an alternative site, please notify the scheduler.

- [ ] **I have received the written notification of alternative testing sites and wish to have my testing done at Beaumont Family Practice.**
- [ ] **I have received the written notification of alternative testing sites and wish to have my testing done at another facility as listed below.**

Other Facility

Signature

Date

FINANCIAL POLICY

Patient Name

To help us help you with the costs associated with your care, we have developed the following financial policy. We want to make your visit with us a pleasant one. Please read and sign a copy of this before we provide any treatment.

INSURED PATIENTS: We welcome all patients and many, but not all, insurance plans. Please be aware that all insurance copayments, deductibles, and non-covered charges need to be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. This will require that you present your current insurance card at each visit. If you present an expired card or inaccurate information, we will be unable to bill your insurance company, and you will be responsible for the total amount of the billed services. It is your responsibility to know your insurance plan. If you are in doubt as to whether a procedure, lab test, or radiological service is covered, or if you are unsure as to where it must be performed, please call your plan's member services department prior to that service. Our office cannot be responsible for out-of-pocket expenses incurred as a result of utilizing the wrong provider, facility, or for having undergone non-covered tests or procedures. Even a verbal verification of benefits or coverage by your insurance company is never a guarantee of payment.

UNINSURED PATIENTS: We welcome our uninsured patients. Please know that payment in full is due at the time of service for all office visits and/or procedures, unless other arrangements have been made in advance. Self pay patients with no balances on their account may be given cash pay prices for all services paid in full at time of service. Some exclusions may apply. If payment is not made on the date of service cash pay prices will not apply and full price of services will be due.

DELINQUENT ACCOUNTS: Your care is our responsibility; your bill is your responsibility. Balances in excess of 60 days must be paid prior to any additional services being rendered. In the event that an account remains unpaid, delinquent accounts will be reported to Collection Management Services. This will result in a blemish on your credit report if unpaid as well as a possibility that you and your immediate family members may be discharged from this practice.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. Your understanding of our financial policy is important to our professional relationship.

☐ **I have read and understand the Beaumont Family Practice Associates Financial Policy. I understand that ultimately I am responsible for payment in full of any outstanding balances incurred during the course of my treatment.**

MINOR PATIENTS: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Signature

Date

YEARLY PREVENTIVE VISITS

Patient Name

When you are in for your yearly preventive visit your insurance company will be billed for a PREVENTIVE EXAM which is covered by most insurances at 100%. During your PREVENTIVE EXAM if other problems are discussed with the provider such as elevated blood pressure, cholesterol issues, diabetes – elevated blood sugars, or any other illnesses, your insurance company will also be billed for a REGULAR OFFICE VISIT which will go towards your co-pay or deductible. These billing procedures are not dictated by this office but by government agencies which structure correct coding. We know that this can be very confusing to you. If you have any questions, please contact our billing department.

Signature

Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY CONSENT FORM

Patient Name

Accurate prescription history reduces medication errors and enhances patient safety. By authorizing Beaumont Family Practice and its affiliated providers, to view your external prescription history provides our staff with information about medications you are already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form you are agreeing that Beaumont Family Practice and its affiliated providers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Signature

Date