Welcome to BFPA

Welcome to Beaumont Family Practice

Our goal at Beaumont Family Practice is to serve your medical needs in a safe, friendly, compassionate environment with the utmost care.

APPOINTMENT TIMES

Monday - Friday

8:20 - 4:15

OFFICE HOURS

Monday - Friday

8:00 - 5:00

We request that all medication refills be addressed during office hours. Patient charts are only available during office hours; therefore, no prescription refills are called in after 5:00pm. Patients are encouraged to call their pharmacy first, to confirm a prescription refill is needed.

Antibiotics as well as narcotic medication will not be called out. These prescriptions require that you make an appointment to see a provider.

Hospital Admits are provided by our contracted hospitalist. We admit directly to Dr. Aldrich for Baptist Hospital, and Reliance Physicians for Christus St. E., who will follow your care during any hospital admission. You will be advised to follow up with this practice upon discharge from the hospital.

One of our Nurse Practitioners or Physician's Assistant is on call through our answering service Monday through Friday from 5:00PM until 10:00PM as well as Saturday and Sunday from 9:00AM to 10:00PM. If you should require medical attention other than those times or if you are confronted with a serious medical concern, you should seek immediate care at a local

Emergency Room or Minor Care.

Please be advised when establishing at Beaumont Family Practice Associates 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.

If you have any suggestions, complaints or comments, contact Shelley Williams, Office Manager.

☐ **I have read and understand the above.**

Signature

Date

New Patient Form

Patient Information

Patient First Name

Patient Middle Name

Patient Last Name

DOB

Sex

☐ Male ☐ Female ☐ Other

Social Security

Explain

Marital Status

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone

Mobile/Cell

Email

Mailing Address

City

Zip

Emergency Contact

Relation

Phone

Occupation

Employed By

Employer's Address

Work #

Name of Spouse/Parent

Occupation

Employed By

Employer's Address

Referred By

Demographics

Primary Language

Bilingual?

☐ Yes ☐ No

Ethnicity

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Race

☐ White/Caucasian ☐ Hispanic/Latino

☐ Black/African American ☐ Asian ☐ Decline

☐ Other

Please specify

Insurance Information

Primary Medical Insurance

Insurance Company

Policy #/Member ID

Group #

Policy Holder Name

Policy Holder Social Security #

Policy Holder DOB

Policy Holder Employer

Policy Holder Address

Policy Holder Phone #

Policy Holder Cell/Work #

Relationship to Insured

☐ Self ☐ Spouse ☐ Child

Secondary Medical Insurance

Insurance Company

Policy #/Member ID

Group #

Policy Holder Name

Policy Holder Social Security #

Policy Holder DOB

Policy Holder Employer

Policy Holder Address

Policy Holder Phone #

Policy Holder Cell/Work #

Relationship to Insured

☐ Self ☐ Spouse ☐ Child

History

Patient

Age

DOB

Responsible Party

Employment

Referred By

Which of our providers are you requesting to see?

☐ 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 Allergic to

List All Medications You Are Currently Taking

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

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

Do you smoke? ☐ Yes ☐ No

If so, how many packs per day?

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

How Much?

Do you drink alcoholic beverages? ☐ Yes ☐ No

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

By signing this form, I authorize you 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 the person(s) or entity listed below.

☐ **HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records.**

Initial

Date

Limitations on the information you may release subject to this Release Form are as follows:

Release my protected health information to:

Name of Provider

Address

Records requested from:

Name of Provider

Address

The Reason or Purposes for this release of information are as follows

Treatment

Patient Name **Date of Birth** **SS#**

Patient Signature **Date**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

General Consent For Treatment

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.

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. 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

A preventive visit is a yearly appointment intended to prevent illnesses and detect health concerns early on. Preventive services include exams, vaccines, lab tests, screenings and possible radiology. Counseling and education are also provided on topics such as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use. These preventative services may not be covered under your plan's medical benefits. It is the patients' responsibility to call their insurance and find out what preventative services are covered, and communicate with their PCP before their scheduled preventative exam.

All services not covered will be the patients' responsibility.

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.

If you have any questions, please contact our billing department.

Signature

Date

Healow App

Ask Us What's New!

Patients can now schedule an appointment and access their medical records online!

Options Include:

- Communicate with the practice securely and efficiently
- View your personal health records
- Schedule an appointment (Shelby Church, PA, Williams Kujawski, FNP-C, Amber Fling, FNP-C, Stacey Walker, FNP-C)
- View upcoming appointments
- Request refills on prescriptions from a pre-populated list of current refillable medications

Please Visit:

https://healow.com

Or download the healow app

Consent to access your information online:

Patient Name

E-Mail Address

Signature **Date**

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY CONSENT FORM

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.

Patient Name _____

Signature **Date** _____

No Show Policy

No Show Policy for Office Visits | Implemented April 5, 2021

Beaumont Family Practice understands that schedules change, emergencies happen and other important obligations occur that may cause a scheduled appointment to be missed. However, not contacting our office and canceling your appointment in a timely manner, prevent other patients from getting medical treatment.

The new, ***"No Show" Policy for Office Visits*** will help us better utilize available appointments for our patients. The following policy is with regard to patients who fail to keep their scheduled office visit. If you are unable to attend an appointment, Beaumont Family Practice asks that you call in a timely manner so this time can be reallocated to another patient.

- Patients who fail to show up for their scheduled appointment and do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show" fee of $25.00. ***In the event of an actual emergency and prior notice could not be given, consideration may be given.***

How to Cancel Your Appointment

To cancel or reschedule appointments call Beaumont Family Practice at (409)835-0524.

Patient Name

Signature

Date

Administrative Form Fee Policy

There is a $25.00 form fee for completing any form(s) that is not directly related to the reimbursement of medical services. Note: This does NOT include workers compensation.

For compliance purposes, the patient information portions of the form must be completed and signed prior to acceptance.

The $25.00 form fee must be paid before the exchange is made.

Forms will be complete in 5 to 7 days.

☐ **I have read and understand the Beaumont Family Practice Administrative Form Fee Policy**

Signature

Date