6450 Folsom Drive
Beaumont, Texas 77706
Phone (409)835-0524
Fax (409)835-0632

Jay C. Proctor III, M.D.
Bud Church, PA-C
Harry Jae Doyle, FNP-C
Amber Fling, FNP-C
Aaran Gassiott, FNP-C
William Kujawski, FNP-C

WELCOME TO BEAUMONT FAMILY PRACTICE

Our goal at Beaumont Family Practice is to serve your medical needs with the utmost care.

APPOINTMENT TIMES
Monday – Friday
8:20 – 4:15

OFFICE HOURS
Monday – Friday
8:00 – 5:00

We request that all refills be addressed during office hours. No refills will be called in after office hours due to the fact that your chart is not available to our providers following business hours.

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

We admit directly to S.E. TX Pulmonology who will follow your care during any hospital admission. You will be advised to follow up with this practice upon discharge from the hospital.

We have physicians, nurse practitioners or physician's assistants 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.

If you have any suggestions, complaints or comments these may be directed to Sherry Parish, business manager.

Registration Slip

Please Print Date:_____

Name:_____

Address:_____

City:_____ Zip:_____Phone:_____

Cell phone:_____ DOB:_____ Sex:_____

___Single ___Married ___Widowed ___Divorced

Social Security:_____

Occupation:_____

Employed by:_____

Employer's Address:_____Work #:_____

Name of spouse/parent:_____

Occupation:_____

Employed by:_____

Employer's Address:_____

Referred by:_____

Guarantor's Information

Guarantor's Name:_____

Guarantor's Social Security #:_____

Guarantor's DOB:_____

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. _____(initial)
YES NO
(Circle one)

PATIENT NAME:_____AGE:_____DOB:_____

RESPONSIBLE PARTY:_____PHONE:_____

EMPLOYMENT:_____

REFERRED BY:_____

PRESENT ILLNESSES: (List below your primary ailments today): DURATION

_____ _____

_____ _____

_____ _____

PAST HISTORY: (List below all serious illnesses, injuries, or operations): DATE

_____ _____

_____ _____

_____ _____

List any medications you are allergic to:

List all medications you are currently taking:

Family History	Age	Living/state of health (If poor, explain)	Age of death	Deceased/cause of death
SPOUSE				
FATHER				
MOTHER				
SISTERS				
BROTHERS				

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

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

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
Do you drink alcoholic beverages? how much?_____	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?

Boys_____ Ages_____

Girls_____ Ages_____

Age period started_____

Have you had a miscarriage?	Yes	No
Do your periods come at regular intervals?	Yes	No
Do you take birth control pills?	Yes	No

Name of pills_____

Do you have an IUD?

If so, how long?_____

When was your last pregnancy?_____

When was your last normal menstrual period?_____

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 of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

ASSIGNMENT OF BENEFITS FORM

Practice Name: Beaumont Family Practice Associates
Address: 6450 Folsom Drive, Beaumont, TX 77706
Phone: (409)835-0524

Date: _____

Patient's Name: _____

Employer: _____

Claim Group Name/No: _____

ID# or SS#: _____

I hereby instruct and direct: _____ and (if applicable) _____
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.

Dated at: _____ this _____ day of _____, 20_____.
(time) (day) (month) (year)

_____ _____
Signature of patient/guarantor/policyholder Signature of Witness

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MEDICAL RECORDS RELEASE FORM

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: Records requested from:

Name: Beaumont Family Practice Name:_____

Street: 6450 Folsom Dr. Street:_____

City/ST/ZIP Beaumont, TX 77706 City/ST/ZIP:_____

The reasons or purposes for this release of information are as follows:

Treatment

Patient Printed Name:_____ Signature:_____

DOB: _____ SS#_____

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.

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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.

Signature _____ Date _____

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AUTHORIZATION TO DISCLOSE INFORMATION

I, _____, acting on behalf of _____
(Print Name of Patient or legally authorized representative) (Print Name of Patient)

_____hereby authorize the release of information as indicated.

MY HEALTH CARE INFORMATION

1. _____ 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

2._____ 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 Names	List information which may be released
_____	_____
_____	_____
_____	_____

3._____I do not authorize release of any information regarding my admission or treatment. I wish to be a "no information" patient.

_____ _____
Date Signature of Patient or legally authorized rep

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.

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BEAUMONT FAMILY PRACTICE ASSOCIATES

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PATIENT QUESTIONNAIRE

1. What is your primary language?

   _____

2. Are you bilingual?

   _____

3. 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 (if any): _____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Date of Birth: _____

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

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WRITTEN NOTIFICATION OF ALTERNATIVE SITES FOR IMAGING

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.

_____ _____

Signature Date

I have received the written notification of alternative testing sites and wish to have my

testing done at _____

_____ _____

Signature Date

BEAUMONT FAMILY PRACTICE ASSOCIATES
FINANCIAL POLICY

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 co-payments, 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 co-payments 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.

Printed Name: _____

Signature: _____

Date: _____

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YEARLY PREVENTIVE VISITS

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 _____

*** *Ask Us What's New!* ***

Patients are now able to access their own records online!

Incredible Options Include:

- Communicate with our practice securely and efficiently
- View your personal health records
- Requests appointments
- View upcoming appointments
- Request refills on prescriptions from a pre-populated list of current refillable medications

Please Visit:

HTTPS://MYCW7ECLINICALWEB.COM/BFPC/JSP/LOGIN.ISP

to get started!

E-mail address: _____

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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.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Name of Legal Guardian, if applicable