NEW PATIENT HEALTH INFORMATION

(PLEASE DOWNLOAD/PRINT & RETURN- INSRUCTIONS ON LAST PAGE)

(PLEASE USE BLUE OR BLACK INK)

BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

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RECIEVE COMMUNICATIONS & STATEMENTS ELECTRONICALLY? ☐ Yes ☐ No

DOCTOR: _____ TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

SEX: (CIRCLE ONE) MALE FEMALE SOCIAL SECURITY #: _____

EMAIL: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE #: _____ ALTERNATE #: _____

REFERRED BY: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER: _____ PHONE: _____

NEAREST RELATIVE: _____ PHONE: _____

RELATIONSHIP: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

HAVE YOU SEEN YOUR PRIMARY CARE PHYSICIAN IN THE LAST 2 YEARS? **(YES or NO)**

HOW OFTEN DO YOU SEE YOUR PRIMARY CARE PHYSICIAN? _____

REASON CHANGING PHYSICIANS: _____

HAVE YOU EVER BEEN DISCHARGED FROM ANOTHER PRACTICE? **(YES or NO)**

DO YOU CHANGE PHYSICIANS FREQUENTLY? **(YES or NO)**

HOW MANY TIMES HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST YEAR? _____

WHAT SPECIALISTS DO YOU SEE? _____

INSURANCE NAME: _____ INSURANCE PHONE #: _____

MEMBER ID #: _____ GROUP #: _____

IT IS REQUIRED FOR YOU TO COMPLETE ALL THE TABLES BELOW. IF IT DOESN'T APPLY STATE

"NONE"

- **PRESENT ILLNESS:** List your primary ailments as of today and how long you have had them.

Current Medical Issues How Long?	How Long?

- **PAST HISTORY:** List all serious illnesses, injuries and operations.

Procedure/Illness	Year

- **List ALL** medications including vitamins/herbal supplements.

Procedure/Illness	Year

ALLERGIES: _____

Circle YES or NO to the following questions.

EAR, NOSE & THROAT:

Do you have any type of eye disease? **YES \ NO**
Do you have any type of ear disease? **YES \ NO**
Do you have any type of hay fever or sinus trouble? **YES \ NO**
Do you have frequent sore throats? **YES \ NO**

CHEST:

Have you ever had a chronic chest condition?
(Such as asthma, bronchitis, etc.?) _____ **YES \ NO**
Do you smoke? Pack/day? _____ **YES \ NO**

CARDIOVASCULAR:

Has a Dr. ever said that you had heart trouble? **YES \ NO**
Has a Dr. ever said that you have high blood pressure? **YES \ NO**
Have you ever had rheumatic fever? **YES \ NO**
Do you get tired easily or short of breath? **YES \ NO**
Do your ankles swell at times? **YES \ NO**

GI:

Do you suffer from upset stomach? **YES \ NO**
Has a doctor ever said you had an ulcer? **YES \ NO**
Do you drink alcoholic beverages? **YES \ NO**
Do you partake in recreational drugs? **YES \ NO**
Have your bowel habits changed in the past year? **YES \ NO**

GU:

Have you ever had kidney disease or infection? **YES \ NO**
Have you had frequent urinary tract infections? **YES \ NO**

METABOLIC:

Do you have diabetes? **YES \ NO**
Do you have excessive thirst? **YES \ NO**
Do you have excessive urine output? **YES \ NO**
Do you have thyroid trouble? **YES \ NO**

JOINTS:

Are your joints often painful or swollen? **YES \ NO**

NERVES:

Have you ever had a nervous breakdown? **YES \ NO**
Do you seem to be tense and nervous all the time? **YES \ NO**
Have you ever been a patient in amental health facility? **YES \ NO**

FAMILY HISTORY:

PLEASE CIRCLE THE STATE OF HEALTH FOR THE FOLLOWING PEOPLE.
IF DECEASED PLEASE GIVE THE CAUSE OF DEATH:

SPOUSE: GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____

FATHER: GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____

MOTHER: GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____

SISTERS: GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____

BROTHERS: GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES?

- SUGAR DIABETES **YES \ NO**
- T.B. (Tuberculosis) **YES \ NO**
- HEART TROUBLE **YES \ NO**
- HIGH BLOOD PRESSURE **YES \ NO**
- EPILEPSY **YES \ NO**
- SEVERE RHEUMATISM **YES \ NO**
- CANCER **YES \ NO**

Has anyone in your family ever been a patient in a mental hospital? **YES \ NO**
Has anyone in your family ever committed suicide? **YES \ NO**

FOR WOMEN ONLY:

How many children do you have? _____ Ages: _____

Have you ever had a miscarriage? YES NO

When was your last menstrual period? _____

Do your periods come at regular intervals? YES NO

When was your last pregnancy? _____

WE WILL FILE PRIMARY AND SECONDARY INSURANCE FOR YOU.
WE DO NOT FILE A THIRD INSURANCE.

I, THE UNDERSIGNED, CERTIFY THAT I HAVE INSURANCE COVERAGE WITH _____ INSURANCE COMPANY.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID FOR BY INSURANCE. I HEREBY AUTHORIZE BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

CO-PAYS, CO-INSURANCE AND DEDUCTABLES ARE DUE THE DAY OF SERVICE. PLEASE REVIEW OUR FINANCIAL POLICIES FOR FURTHER INFORMATION.

NAME OF PRIMARY INSURANCE: _____
ID #: _____
GROUP #: _____

Today's Date: _____

Patient's Name: _____ **DOB:** _____

TO BE COMPLETED BY NURSE AT TIME OF VISIT!

Did you bring a current medication list today? **YES / NO**

Depression Screening: Do you have little interest or pleasure in doing things? **YES / NO**

Feeling down, depressed, or hopeless? **YES / NO**

TO BE COMPLETED BY PATIENT PRIOR TO OFFICE VISIT!

Advanced Care Planning: Do you have any of the listed advanced care plans? Circle all that apply: LIVING WILL, MEDICAL POWER OF ATTORNEY, DNR, OTHER: _____

Who have you named as your Surrogate Decision Maker? _____ / **NONE**

If you circled yes to any of the Advanced Directives, please make sure your physician has a copy on file.

If you were to suffer a life altering event, like a STROKE,

Who best understands the care you would want?

Who do you turn to for help, when working through a crisis?

What kind of personal care would you accept? **CIRCLE:** Home Health, Hospice, Nursing Home, Private Care Providers, Assisted Living. Any means necessary, Depends on circumstances, Skilled Nursing, Other: _____

Have you been hospitalized in the last year? YES / NO.

Do you use any assist devices? **CIRCLE:** NONE, CANE, WALKER, WHEELCHAIR, LIFT CHAIR, BEDSIDE COMMODE, SCOOTER, HOSPITAL BED, SHOWER CHAIR, OTHER: _____

Do you require the assistance of another person with travel? **YES / NO**

Are you compliant with taking your medications as directed? **YES / NO**

If no, please explain _____

Are you compliant with keeping your doctor visits? **YES / NO**

If no, please explain _____

Vaccine Screening: Influenza/FLU: Have you had a influenza vaccine for the current year? ***2023-2024.***

If YES, Date _____ If NO, would you like a vaccine today? **YES / NO**

Pneumococcal vaccine: (65 y/o) Have you ever received a Pneumococcal 23 vaccine? **YES,** Date: _____ **NO.**

Have you ever received a Prevnar 13 vaccine? **Yes,** Date: _____ **NO.**

Have you ever received a Prevnar 20 vaccine? **YES,** Date: _____

If NO, Would you like a vaccine today? **YES / NO**

Osteoporosis Screening: **Female** Dexa Scan: Date of last Dexa scan: Date: _____ Result of last Dexa scan: CIRCLE: Normal, Osteopenia, Osteoporosis, Unknown.

Eye Exam Screening: Routine Eye Exam: Date: _____ Name of eye Care: _____
Provider: _____
Diabetic Eye Exam DATE: _____

Do you have Diabetic Retinopathy? **YES/NO/UNKNOWN.**
Colorectal Cancer Screening: Colonoscopy: Date of Last Colonoscopy: **DATE:** _____ NEVER, Result of Last Colonoscopy: CIRCLE: Normal, Polyps, Diverticulosis, Diverticulitis, Unknown..... Who is your Gastroenterologist?
Breast Cancer Screening: **Female Mammogram:** Date of Last Mammogram: _____
Location: _____

PSA Screening: Men When was your last PSA?
Cognitive-Function Exam The Nurse/ Medical Assistant will screen you in the exam room.
Pain Screening: Overall pain scale of patient's day to day life: On a scale of 0-10 (0-10) _____ (0=No Pain)
When you experience pain, how do you control it?
What part of your body causes you pain?
Do you take prescribed pain meds? **YES / NO**
Do you have a pain doctor? **YES / NO**
Do you want to discuss your pain today? **YES / NO**

Social Health Screening: Smoking: Are you a: **CIRCLE:** Never Smoker, Current Smoker, Former Smoker, Occasional Smoker.
How much do you smoke daily?
Do want to quit smoking? **YES / NO**
Do you use smokeless tobacco? **YES / NO**
Fall Risk Assessment: Have you had a fall in the last year? **CIRCLE:** No falls to report, 1 fall without injury in the Last year, 2-5 falls without injury in the last year, 5+ falls in the last year without injury,
1 fall with Injury in the last year, 2-5 falls with injury in the last year, 5+ Falls in the last year with injury.

FUNCTIONAL ABILITY QUESTIONS **Dementia Patients ONLY.**

Do you require assistance with any of the following? **CIRCLE all that apply.**
Bathing, Dressing, Toileting, Transferring, Continence, Feeding, Meal Preparation, Ordinary Housework, Managing Finances, Managing Medication, Phone Use, Shopping, Transportation

NAME OF SECONDARY INSURANCE: _____
ID #: _____
GROUP #: _____

Printed name of Patient or Personal Representative _____
(If PR. Please list relationship)

_____
Signature of Patient or Personal Representative

DATE _____

PLEASE INITIAL ON EACH LINE BELOW.

_____(Patient's Initials)
PRESCRIPTION HISTORY CONSENT
I fully understand the Prescription History access information provided and stated in the New Patient Packet.

_____(Patient's Initials)
CERTIFIED NURSE PRACTITIONER / CERTIFIED PHYSICIAN ASSISTANT
I understand that certain care maybe provided by a Certified NP, or a Certified PA employed by Beaumont Internal Medicine and Geriatric Associates as stated in the Nurse Practitioner Consent Form provided.

_____(Patient's Initials)
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
I acknowledge that I have received and understand the Authorization to Release Healthcare Info Form. I have authorized the release of my healthcare information to Beaumont Internal Medicine & Geriatric Associates.

_____(Patient's Initials)
PATIENT CONTROLLED SUBSTANCES & PAIN MANAGEMENT AGREEMENT
I fully understand the purpose of the Patient Controlled Substances & Pain Management Agreement is to prevent misunderstandings about certain medicines I will be taking for pain management, anxiety and/or sleep disorders. This is to help both myself and my doctor comply with the law regarding controlled pharmaceuticals.

_____(Patient's Initials)
AUTHORIZATION TO DISCUSS MEDICAL INFORMATION
I understand that by completing the, Authorization To Discuss Medical Information Form, I have Authorize the Use or Disclosure of Protected Health Information (PHI) (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164). Beaumont Internal Medicine & Geriatric Associates may use or disclose PHI as per the terms listed on the Notice of Privacy Practices. The effective period for this permission is from time of this signature moving forward. I understand I have the right to revoke this authorization, in writing, at any time. The PHI are including but not excluded to records relating to mental healthcare, communicable disease, HIV/ AIDS, pregnancies, or treatment of alcohol or drug abuse. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I have read the notice of privacy practices and understand my patient rights regarding my PHI.

_____(Patient's Initials)
PATIENT CONSENT AGREEMENT FOR CHRONIC CARE SERVICES
I acknowledge I have received a paper copy of the Beaumont Internal Medicine & Geriatric Associates-Chronic Care Services Agreement.

_____(Patient's Initials)
ONLINE COMMUNICATIONS INFORMED CONSENT-PATIENT PORTAL
I acknowledge I have received a paper copy of the Beaumont Internal Medicine & Geriatric Associates-ONLINE COMMUNICATIONS INFORMED CONSENT AGREEMENT– PATIENT PORTAL.

_____(Patient's Initials)

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Beaumont Internal Medicine & Geriatric Associates Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Beaumont Internal Medicine & Geriatric Associates cannot be responsible for use or re-disclosure of information by third parties. I acknowledge I have received a paper copy of the Beaumont Internal Medicine & Geriatric Associates-Notice of Privacy Practices.

_____(Patient's Initials)

OFFICE POLICIES & PROCEDURES

I fully understand the office policies and procedures provided and stated in the New Patient Packet, including all codes of conduct and fees that could be assessed to me.

_____(Patient's Initials)

PATIENT FINANCIAL AGREEMENT

I understand my financial obligation for services rendered by Beaumont Internal Medicine and Geriatrics Associated as stated in the Financial Agreement form provided to me.

_____(Patient's Initials)

ASSIGNMENT OF BENEFITS

I hearby authorize BIMGA to release any information necessary to process my BIMGA insurance claims. I also authorize and request payment of medical benefits directly to BIMGA for services rendered to me or my dependents.

Signature of Patient or Personal Representative _____

Printed name of Patient or Personal Representative _____

Date _____

Prescription History Consent

I voluntarily consent to provide Beaumont Internal Medicine & Geriatric Associates access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Beaumont Internal Medicine & Geriatric Associates may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as longas I attend or receive services from Beaumont Internal Medicine & Geriatric Associates, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____ **Print Name:** _____ **Date of Birth:**_____

Signature of Patient/Legally Authorized Representative _____

Relationship to Patient (If patient not signing) _____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

_____

_____

Reader/Translator Signature _____ Date _____

Nurse Practitioner (N.P.)/ Physician Assistant (P.A.)

Consent for Treatment

This facility has on staff a N.P. /P.A. to assist in the delivery of medical care.

Nurse Practitioners (N.P.) / Physician Assistants (P.A.) are not a doctor. A N.P. / P.A. are a graduate of a certified training program and are licensed by the state board. Under the supervision of a Physician, a N.P. / P.A. can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A N.P. / P.A. may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant and/or nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the physician assistant and/or nurse practitioner and request to see a physician.

Printed Name _____ **Signature** _____ **Date** _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Social Security #: _____ Patient's Phone: _____
Patient's Address:_____ City:_____
State:_____ Zip:_____

I request and authorize:
Name of healthcare provider(s) or facility to release in _____

Address: _____ City: _____

State:_____ **Zip:** _____ **Phone:** _____ **Fax:** _____

To release healthcare information on the patient named above to:

Beaumont Internal Medicine & Geriatric Associates

755 N. 11th Street Suite P-5200, Beaumont, TX 77702

Fax: 409-899-5542

The following information is to be disclosed:

YES	NO	
☐	☐	Physician Notes
☐	☐	Lab Results
☐	☐	Cardiac Studies
☐	☐	Pulmonary studies
☐	☐	X-ray/diagnostic imaging reports
☐	☐	Complete record
☐	☐	Other_____

I understand that my medical record may contain reports, test results & notes that only a physician can interpret. I understand I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding the information.

I will not hold Beaumont Internal Medicine & Geriatric Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for his/her interpretation.

I understand the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency (HIV). It may also include information about behavioral or mental health services or treatment for alcohol &drug abuse.

Right to revoke: I understand I have the right to revoke this authorization at any time. I understand my revocation must be in writing. I understand the revocation will not apply to information already released.
Other rights: I understand I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (If an expiration date, event or condition is not specified, this authorization will expire in 6 months).
DATE OF EXPIRATION: _____

Signature of Patient or Legal Representative: _____
If signed by representative, what is relationship? _____
Date: _____

PATIENT MEDICATION AGREEMENT

Due to DEA regulations, the following guidelines will be strictly followed for all patients taking controlled medications of any kind

- Urine Drug Screen at least twice a year
- Patients may choose ONE pharmacy for their controlled medications to be filled at, which will be listed below in this agreement. If for any reason the pharmacy needs to be changed, it is the patient's responsibility to notify our office in a timely manner as well as updating the pharmacy information on this form.
- Patients MUST be seen by a provider EVERY THREE MONTHS (NP, PA, or Doctor)
- MUST be seen by the Doctor at least once a year in order to continue to receive refills for their controlled medication. If patients cancels or no-show for their follow-up appointment, their controlled medication will not be refilled until they are seen.
- Patients are expected to schedule their follow-up appointments before leaving our office after current visit. There will be no work-in appointments for controlled medication refills. It is the patient's responsibility to schedule their 3 month follow-up appointments.
- Controlled medications will be refilled every 30 days, please contact our office within 24 hours of your medication refill date (unless due date falls on a Sunday)

We apologize for any inconvenience this may cause. We, as a clinic, hope you understand that due to the DEA regulations, we have to be in compliance, especially in regards to controlled medications. If you have any questions or concerns, please feel free to discuss at your appointment.

I AGREE TO USE _____ PHARMACY LOCATED AT _____ FOR FILLING ALL MY CONTROLLED MEDICATIONS

I understand my doctor and the pharmacy will cooperate fully with any city, state, federal law enforcement agency or regulatory board in the investigation of any possible misuse, sale or other diversion of my controlled medication(s). I authorize the provision of this Agreement to my pharmacy. I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations.

I agree I will use my medicine at a rate no greater than the prescribed rate. I will not attempt to obtain any controlled medications for other physicians. I will not share, sell or trade my medications with anyone. I will not use any illegal controlled medications. I will safeguard my medications from loss or theft. Lost or stolen medications will NOT be replaced.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me.

THIS AGREEMENT WAS ENTERED ON (Date): _____

_____ Patient Signature

_____ Patient Name (Please print)

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION (HIPAA)

I, _____, give permission to Beaumont Internal Medicine & Geriatric Associates to
(PATIENT NAME)
discuss any of my medical information with the following individuals:

Name: _____ **Phone:** _____
Email: _____
Relationship: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian **Other:** _____

Name: _____ **Phone:** _____
Email: _____
Relationship: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian **Other:** _____

Name: _____ **Phone:** _____
Email: _____
Relationship: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian **Other:** _____

Name: _____ **Phone:** _____
Email: _____
Relationship: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian **Other:** _____

_____ _____
Patient Signature Date

Patient Consent Agreement for Chronic Care Services

Medicare now offers a new benefit for patients with multiple chronic diseases, and by Consenting to this Agreement, you designate your provider, Dr. "Provider", to provide chronic care management (CCM) services per the new rule.

Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don't have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Provider Chronic Care Services

As part of this new benefit, your Provider agrees to make available the following services:

1. 24/7 access to a healthcare provider to address your acute chronic care needs
2. Use of certified EHR software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversight
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Consent Terms

By signing this Agreement, you agree to the following terms required by Medicare:

1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30) - day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Services.
5. You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Signature: _____ **Print Name:** _____

Date: _____

PATIENT ACKNOWLEDGEMENT/ CONSENT
ONLINE COMMUNICATIONS INFORMED CONSENT – PATIENT PORTAL

Secure Email Address: _____
Patient Name: _____ DOB: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian requesting access _____

Relationship to the patient: _____ **Date:** _____

Our Patient Portal site may be accessed by two different URL's.

Our Website: **www.bimga.com**

Patient Portal direct site: https://health.healow.com/bimga

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

Signature of Patient /Parent/Guardian: _____ **Date:** _____

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, or any other illnesses, your insurance company will also be billed for a **REGULAR OFFICE VISIT** which could 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.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

HOW TO RETURN PAPERWORK

CHOOSE ONE OF THE FOLLOWING:

- **Email** to: **newpatient@bimga.com**
- **Fax** to **409-898-2592**
- **Drop off** at 755 N 11th St Suite P5200 Beaumont TX 77702
- **Mail** to 755 N 11th St Suite P5200 Beaumont TX 77702

ONCE THE PAPERWORK HAS BEEN RECEIVED A NEW PATIENT COORDINATOR WILL:

- Review paperwork
- Verify insurance
- Submit to doctor for review
- Make a chart
- Call to schedule an appointment

TO ENSURE A QUICK AND SEAMLESS PROCESS:

- Fill paperwork out completely
- Include insurance information (cards if possible)
- Change your primary care provider with insurance company (this has to be done prior to an appointment being made for HMO plans)

BIMGA
BEAUMONT INTERNAL MEDICINE
& GERIATRIC ASSOCIATES

THANK YOU!

FOR QUESTIONS E-MAIL

newpatient@bimga.com