GARY R. CLAYTON, M.D., P.A.

PATIENT INFORMATION - PLEASE PRINT CLEARLY	
Last Name	
First Name	
Middle Initial	
Home Address	
City	
State	
Zip Code	
Home Phone	
Cell Phone	
Work Phone - Extension	
Date of Birth	
Sex	
Marital Status	
Social Security Number	
Employer	
Employer Address	
Employer Phone	
Email Address	
Race	

Initials: -_____-

Ethnicity	
Emergency Contact	
Relation	
Phone Number	
PRIMARY INSURANCE INFORMATION	
Insurance Company Name	
Policy Number	
Group Number	
Cardholder's Name	
Relation to Cardholder (if not self)	
Cardholder's Date of Birth (if not self)	
Cardholder's Social Security Number	
Cardholder's Employer (if not self)	
Cardholder's Employer's Phone Number (if not self)	
SECONDARY INSURANCE INFORMATION	
Insurance Company Name	
Policy Number	
Group Number	
Cardholder's Name	
Relation to Cardholder (if not self)	
Cardholder's Date of Birth (if not self)	
Cardholder's Social Security Number	
Cardholder's Employer (if not self)	
Cardholder's Employer's Phone Number (if not self)	
We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurcance plan provides for you. I understand that I am financially	

Initials: -_____-

responsible to the providers at Gary R. Clayton, M.D., P.A. for any balance not covered by the insurance carrier(s). I hereby assign and authorize my insurance benefits for services performed by the providers of Gary R. Clayton, M.D., P.A. to be paid directly to Gary R. Clayton, M.D., P.A. **I HAVE READ AND FULLY UNDERSTAND THE ASSIGNMENT OF BENEFITS SET FORTH BY GARY R. CLAYTON, M.D., P.A. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY OR AN ATTORNEY, I WILL ALSO BE RESPONSIBLE FOR ANY AND ALL FEES CHARGED, INCLUDING COURT COSTS, ATTORNEY'S FEES, AND COLLECTIONS' FEES, BY THE AGENCY OR ATTORNEY FOR THE COSTS OF COLLECTING THE DEBT IN ADDITION TO THE ORIGINAL AMOUNT(S) DUE.**	
Signature	
Relation, if other than Patient	
Date Signed	

Initials: -_____-

GARY R. CLAYTON, M.D., P.A.

Patient Name	
Date of Birth	
Appointment Date	

CURRENT MEDICATIONS- Please list below or provide us a list you already have prepared.			
MEDICINE WITH DOSE	**DIRECTIONS**	**MEDICINE WITH DOSE**	**DIRECTIONS**
Example- Metformin 500 mg	1 pill(s) 2 time(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day
	___ pill(s) ___ times(s) a day		___ pill(s) ___ times(s) a day

MEDICAL HISTORY- Please circle the items that pertain to you. Please list and not listed.				
Acid reflux	Chronic sinusitis	Heart murmur	Multiple sclerosis	Stroke
Alcoholism	Cirrhosis of liver	Hepatitis A, B or C	Mumps	TB (Tuberculosis)
Anemia	Colon polyps	Hernia	Osteoporosis	TB skin test positive
Anorexia	Crohn's disease	High blood pressure	Ovarian cyst	Thyroid problems

Initials: -_________-

Appendicitis	Depression	High cholesterol	Pancreatitis	Tobacco abuse
Arthritis	Diabetes	High triglycerides	Parkinson's disease	Tonsillitis
Asthma	Diverticulitis	HIV or AIDS	Pneumonia	Whooping cough
Bleeding disorder	Emphysema	Irregular heart beat	Polio	OTHER- Please list-
Blood clots	Fatty Liver	Irritable bowel syndrome	Psoriasis	
Blood transfusion	Frequent kidney infections	Kidney disease/failure	Psychiatric care	
Bulimia	Frequent bladder infections	Kidney Stones	Radiation therapy	
Cancer	Frequent lung infections	Liver disease	Rheumatic fever	
Chemical dependency	Gallstones	Lung disease	Rubella	
Chest pain/angina	Glaucoma	Lupus	Sciatica	
Chickenpox	Gout	Measles	Seizures	
Chronic anxiety	Heart attack	Migraines	STD	
Chronic cough	Heart disease	Milk Intolerance	Sleep apnea	
Chronic lung disease	Heart failure	Mononucleosis	Stomach ulcer	

Initials: -_____-

GARY R. CLAYTON, M.D., P.A.

Patient Name	
Date of Birth	
Appointment Date	

ALLERGIES- if you do not have any allergies, please note that below.	
Medicine / Item	**Reaction**

SURGERIES	
PROCEDURE	**DATE (IF AVAILABLE)**

HOSPITALIZATIONS (other than for surgeries)	
REASON	**DATE (IF AVAILABLE)**

Initials: -_____-

FAMILY HISTORY- Please list any diseases or conditions that affect the family member below-

FAMILY MEMBER	**DISEASE OR CONDITIONS**
Mother	
Father	
Grandmother	
Grandfather	
Brother	
Sister	
Son	
Daughter	
OTHER-list below	

Initials: -_________-

GARY R. CLAYTON, M.D., P.A.

Patient Name	
Date of Birth	
Appointment Date	

SOCIAL HISTORY	
Marital Status- __Married __Single __Divorced __Widowed	
Number of children	
Ages	
Occupation- _____ __unemployed __retired __student	
Have you ever smoked? ___no ___yes; _____ packs per day for ___years	
Do you currently smoke? __no __yes	
Do you or have you used smokeless tobacco? __no __yes; details:	
Alcohol use- ___no __ yes; _____ drinks per day for ___ years	
Non-prescribed drugs- ___ no ___ yes; specify drugs and amounts:	
Caffeine- ___ no ___ yes; ____ drinks per day	
Are you sexually active? ___ no ___ yes	
Are you currently on any special diet? ___ no ___ yes; details:	

PREVENTATIVE QUESTIONNAIRE	
Date of last flu vaccine	
Date of last pneumonia vaccine	
Date of last tetanus vaccine	
When was your last colonoscopy? _____ Were the results normal? __yes __no; details below	
When was your last bone density test? _____ Were the results normal? __yes __no; details below	

FEMALE PATIENTS ONLY	
When was your last mammogram? _____ Were the results normal? __yes __no; details below	
When was your last pap smear? _____ Were the results normal? __yes __no; details below	
When was your last menstrual period?	
Number of pregnancies	
Number of live births	
Who is your OBGYN?	

Initials: -_____-

Other female related complications:

MALE PATIENTS ONLY
When was your last prostate exam? _____ Were the results normal? __yes __no; details below
When was your last PSA? _____ Were the results normal? __yes __no; details below
Other male related complications:

OTHER PROVIDERS	
What is the name of your dentist?	
What is the name of your previous Primary Care Provider?	

SPECIALIST'S NAME	**REASON FOR SEEING**
Example - Dr. Margolis	Hypertension

Initials: -_____-

GARY R. CLAYTON, M.D., P.A.

Practice Policies

Dr. Clayton and his staff are committed to providing you with the best care available. Our goal is only achieved if everyone is aware of the practice policies, which are agreements between the provider(s) of the practice and the patient or patient's guardian(s). Your clear understanding of this practice policy agreement is important to our professional relationship.

INSURANCE

Payment for services is due at the time services are rendered. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide correct, active insurance card(s) at the time of check-in for each visit. Inaccurate or untimely information, which results in denial or reduced coverage by your insurance company will result in you, the patient, being responsible for any remaining balance and resubmission of the claim to your insurance company for payment. Health insurance is a contract between you, your employer (if applicable), and your insurance company. Your insurance plan sets the amounts of your co-pay, co-insurance and deductibles. It is important for you to be an informed consumer who understands the specifications of your insurance policy (e.g., vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiographs, laboratory tests, emergency hospital care, etc.).

BILLING AND PAYMENTS

We accept cash, checks, MasterCard, Visa and Discover. Unfortunately, we are not equipped to accept credit card payments over the phone or without the card being present in the office for swiping. Co-pays and co-insurance are due at the time services are rendered here in the office. If you do not have your co-pay or co-insurance, your appointment may be rescheduled. The practice reserves the right to charge an interest charge of eighteen percent per year (1.5% per month) on balances that remain on your account after the first statement.

If your account is forwarded to a collection agency, our professional relationship will be terminated, give you 30 days notice to find a new provider for your medical care needs.

A $35 return check fee will be charged for all checks returned by your bank for any reason and your account will be placed on a "cash-only basis". We will accept payments only by cash or credit card for any balances and future charges.

Should your account balance become uncollectible due to bankruptcy, we will terminate our professional relationship, giving you 30 days to find a new provider for your medical care needs.

Initials: -_____-

SUBMISSION OFF CLAIMS FOR SERVICES AND INSURANCE PAYMENTS

All services performed in our office and at the hospital will be submitted to your primary and secondary insurances as a courtesy to you. Any tertiary insurance will need to be filed by the patient. If you do not provide the correct insurance information at the time of service, you may be charged a rebilling fee of $15 per date of service to cover the administrative costs of resubmitting the claims(s). If the patient declines the fee, the patient will be required to make payment to the provider directly for the medical care provided and submit the claim to their insurance for reimbursement. All co-payments, deductibles and coinsurances are your responsibility and will also be collected at the time of service. We will do our best to calculate these amounts using information provided by your insurance plan. Most insurance plans have a negotiated rate for all covered services provided by our office. Your insurance may not cover 100 percent of the negotiated rate for any or all services provided. All balances remaining after insurance payment, including partial payment or denial will be due from you, the patient, and will be included in your monthly statement. If you have question regarding what services your insurance plan covers or about the amount that your insurance plan will cover for a specific service, please contact your insurance company directly.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. For cancellations, 24 hours' notice prior to the appointment is required. A $30 fee will be charged for appointments missed without 24 hours' notice. This fee must be taken care of before your next appointment or any medical treatment is provided.

FORMS FEES

There is a $25 prepayment fee for the review and completion of forms. This fee is per page (front and back) of disability, FMLA, return-to-work or any forms not related to payment to this office for services rendered. This office will not complete forms without prepayment of the fee. We have a 3 to 5 day turnaround time for forms. Calls to the office will not expedite this process.

MEDICAL RECORDS FEES

There is not a fee for fax copies of records to other healthcare providers. If you require or desire a paper copy of all your Gary R. Clayton, M.D., P.A. provider records, a $25 prepayment fee for the first 20 pages with 15 cents per page for all additional pages is required.

REFERRALS

If your insurance plan requires a written referral for you to see a specialist, or for procedures or laboratory tests, you must allow us 3 business days to complete the appropriate form(s) prior to

obtaining services. You may have to reschedule your appointment with the specialist / facillity if less than 3 business days' notice is not given to prepare your referral. Retroactive referrals will not be written. We will not agree to a referral for a problem we have not addressed and referred you to the specialist / facility. It is important that as questions arise, you contact your insurance company directly for final guidance and clarification.

REFILLS

Our goal is to process refills and all other requests as quickly as possible. We ask that patients provide at least a two days notice before needing medication refill(s) at local pharmacies and at least one week notice for mail order pharmacies. Patient should contact their pharmacy for all refills. The pharmacy / physician contact is the fastest and most efficient way of getting refills. All refills will be addressed during normal 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 AND NARCOTIC MEDICATIONS

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

AFTER HOUR PHONE CALLS

The office telephone lines are rolled to our answering service outside of normal business hours. the answering service takes messages during these times. Providers or providers on-call should not be paged through the answering service for non-urgent medical matters, including prescription refills. Abuse of the answering service may result in the patient being terminated from the practice. **If you have an emergency, you should seek immediate medical care at a local emergency room or dial 911.**

Initials: -_____-

GARY R. CLAYTON, M.D., P.A.

Practice Policies

CONSENT / AUTHORIZATION FOR TREATMENT & TO RELEASE INFORMATION / DISCLOSE HEALTH INFORMATION

The signature below serves as authorization for medical treatment by the physician, nurse or other provider of Gary R. Clayton, M.D., P.A. for the named patient. It also provides authorization for Gary R. Clayton, M.D., P.A. to furnish and / or release any information necessary to insurance carriers, third party administrators, self-insured administrator, and / or other health payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record and / or prescription history from other physician practices, clinics, pharmacies, and / or medical facilities. A copy of this authorization may be used in place of the origginal in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

ASSIGNMENT OFF BENEFITS AND FINANCIAL AGREEMENT

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS SET FORTH BY GARY R. CLAYTON, M.D., P.A. I AGREEE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY OR AN ATTORNEY, I WILL ALSO BE RESPONSIBLE FOR ANY AND ALL FEES CHARGED, INCLUDING COURT COSTS, ATTORNEY'S FEES, AND COLLECTIONS' FEES, BY THE AGENCY OR ATTORNEY FOR THE COSTS OF COLLECTING THE DEBT IN ADDITION TO THE ORIGINAL AMOUNT(S) DUE.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

Initials: -_____-

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the chance to review 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 at my request.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

Initials: -_____-

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. **PATIENT INFORMATION**

Name:

Address:

City, State Zip:

Social Security:

Date of Birth:

2. **HEALTHCARE ENTITY**

Name:

Address:

City, State Zip:

Phone:

Fax:

3. **AUTHORIZATION FOR RELEASE.** I hereby authorize the entity listed in **Section 2** to release, disclose, and deliver the medical information described in **Section 4** to **GARY R. CLAYTON, MD, 740 HOSPITAL DRIVE SUITE 210, BEAUMONT, TX 77701, PHONE: (409) 839-4757.**

4. **INFORMATION TO BE RELEASED.** Information to be released:

_____ Complete Medical Record,
_____ OR ONLY ITEMS LISTED BELOW:

_____
_____
_____
_____
_____

Initials: -_____-

5. **REDISCLOSER.** This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

6. **VALIDITY.** I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Signature of Patient: * _____

Date of Request: * _____

Initials: -_____-

GARY R. CLAYTON, M.D., P.A.

740 Hospital Drive Suite 210

Beaumont, Texas 77701

(409) 839-4757

CONSENT FOR RELEASE OF TEST RESULTS

___ I will allow all test results including **ABNORMAL** results to be released to the following people:

Name	Relation

___ I do **NOT** want **ANY** of my test results release to anyone buy myself.

_____

Printed Name of Patient

_____

Patient's Date of Birth

_____

Signature of Patient

_____

Date*

Initials: -_____-

*This consent will expire one year from the date above.

Initials: -_____-