NAME _____

BIRTH DATE _____

ADDRESS _____

_____

HOME PHONE # _____

MOTHER'S WORK # _____

PARENTS NAMES _____

SIBLINGS NAMES & BIRTH DATES

_____

FATHER'S WORK _____

FATHER'S WORK # _____

DATA													
DATE													
AGE	6 YR	7 YR	8 YR	9 YR	10 YR	11 YR	12 YR	13 YR	14 YR	15 YR	16 YR	17 YR	18 YR
WEIGHT													
HEIGHT													
BP													
HCT													
UA													
CHOLESTEROL													
VISION													

PROBLEM LIST													
1													
2													
3													
4													

CLEBURNE PEDIATRICS, P.A.
INSURANCE VERIFICATION FORM

PATIENTS NAME: _____

DOB: _____

NAME OF INSURANCE: _____

Please furnish information of the person who carries the insurance:

INSURED'S NAME: _____

DOB: _____

SSN#: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

OCCUPATION: _____

GROUP #: _____

ATTENTION

CLEBURNE PEDIATRICS FILES YOUR INSURANCE AS A COURTESY. THERE IS NO GUARANTEE OF REIMBURSEMENT. PLEASE REMEMBER, YOU ARE ULTIMATELY REPSONSIBLE FOR ANY AND ALL CHARGES.

_____ _____
SIGNATURE DATE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient(s) _____
Date of Birth _____

I, the undersigned, authorize the release of health information for the aboved named patient(s) to:

Cleburne Pediatrics, P.A.
215 N. Ridgeway Dr
Cleburne, TX 76033
(817) 774-2560
(817) 774-2563 (Fax)

Physician's Name: _____
Address: _____
City, State, Zip: _____
Phone or Fax Number: _____

My authorization extends only to ALL RECORDS AND ANY SPECIFIED DATA ELEMENTS:
Specific dates include or are limited to: _____
Other (must specify) _____

THIS AUTHORIZATION IS GIVEN FREELY AND WITH UNDERSTANDING THAT:

- *****Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.**
- *****A photocopy or fax of this authorization is as valid as this original.**
- *****I may revoke this authorization at any time, except where information has already been released to revoke my authorization, I must submit a Revocation of Authorization to Release medical information Form to the clinic. The clinic will act upon my revocation within (2) working days of receipt. This authorization is valid for a one year period from the date it is signed or sooner if noted below.**
- *****Cleburne Pediatrics, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**
- *****Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may longer be protected by this rule.**
- *****Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.**
- *****Patient will be provided with a copy of this authorization.**

PATIENT/LEGAL GUARDIAN SIGNATURE _____
DATE_____
RELATIONSHIP TO PATIENT _____
EXPIRATION DATE OF THIS AUTHORIZATION _____
WITNESS _____ DATE_____

EXHIBIT B

PATIENT CONSENT FORM

I understand that as part of my healthcare, CLEBURNE PEDIATRICS ("PHYSICIAN") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

☐ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PHYSICIAN's *Notice of Privacy Practices* dated 4/1/03.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative

*I request that changes to the *Notice of Privacy Practices* be sent to me at this

address: _____

_____

PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

CLEBURNE PEDIATRICS, P.A. 215 NORTH RIDGEWAY DR CLEBURNE, TX 76033

DR. RANBIR K. SHARMA, M.D. SARA CHANDLEE, P.A.

This facility has on staff a physician assistant to assist in the delivery of medical (may indicate specialty) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

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

A physician assistant may provide such medical services that are within his/hers 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
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and herby consent to the services of a physician assistant for my health care needs.

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

Name:	Date:
Signature:	Witness (optional):

Revised 05-23-06

Texas Vaccines for Children Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name:____

   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:______________________________

   Last Name First Name MI

4. Primary Provider's Name:____________________________________

   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, the child is eligible for the TVFC program. If column G is marked the child is not eligible for TVFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are eligible for vaccines through the TVFC program as long as the provider bills CHIP for the administration of the vaccine.*

**** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

CLEBURNE PEDIATRICS,P.A. PATIENT INFORMATION FORM **TODAYS DATE** _____

NOTE: ALL NAMES LISTED WILL BE CONSIDERED LEGALLY ABLE TO ATTEND WITH PATIENT AND MAKE DECISIONS IN OFFICE

* _____

PATIENT LAST NAME, FIRST NAME, MIDDLE INITIAL DATE OF BIRTH

* _____

STREET ADDRESS MALE OR FEMALE

* _____

CITY , STATE, ZIP CHILD SSN

* _____

HOME PHONE CELL PHONE

* _____

NAME OF NEAREST FRIEND OR RELATIVE CONTACT NOT LIVING WITH YOU

* _____

THEIR ADDRESS CITY, STATE, ZIP

* _____

THEIR PHONE#

* _____

MOTHER S LAST NAME, FIRST , MIDDLE INITIAL DATE OF BIRTH DRIVERS LICENSE

* _____

EMPLOYER PHONE#

* _____

OCCUPATION/JOB DESCRIPTION /TITLE MOTHER SSN

* _____

FATHER S LAST NAME, FIRST , MIDDLE INITIAL DATE OF BIRTH DRIVERS LICENSE

* _____

EMPLOYER PHONE#

* _____

OCCUPATION/JOB DESCRIPTION/ TITLE FATHER SSN

* _____

OR CUSTODIAL GUARDIAN NAME DATE OF BIRTH DRIVERS LICENSE

* _____

ADDRESS GUARDIAN SSN

* _____

GUARDIAN HOME PHONE CELL PHONE WORK PHONE

List any other persons that are authorized to allow this patient to receive medical care and make medical decisions in reference to this patient while at this office :

_____

name relationship name relationship

_____

name relationship name relationship

signature of parent or Guardian_____

NOTE: WE DO NOT FAX INFORMATION TO ANYONE OTHER THAN OFFICES IN RELATION TO CARE OF CHILD WITHOUT PARENT OR GUARDIAN RELEASE OF INFORMATION FORM. PLEASE DO NOT ASK US TO FAX INFO