



BEYOND CARE  
PEDIATRICS

## BEYOND CARE PEDIATRICS PATIENT INFORMATION FORM



BEYOND CARE HEALTH SYSTEMS  
WE GO BEYOND TO CARE

PATIENT'S FULL NAME: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SEX: FEMALE OR MALE  
PATIENT SSN: \_\_\_\_\_ PHONE: \_\_\_\_\_  
MOTHER'S MAIDEN NAME: \_\_\_\_\_  
CHILD'S ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

### LEGAL GUARDIAN:

MOTHER FULL  
NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
SAME OR DIFFERENT ADDRESS: \_\_\_\_\_  
PHONE : \_\_\_\_\_ SSN: \_\_\_\_\_  
FATHER FULL NAME : \_\_\_\_\_ DOB: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_ SSN: \_\_\_\_\_

### INSURANCE INFORMATION PLEASE CIRCLE ONE OF THE FOLLOWING :

MEDICAID      SELF PAY      PRIVATE INS  
INSURANCE NAME: \_\_\_\_\_  
POLICY ID NUMBER: \_\_\_\_\_ GROUP # \_\_\_\_\_  
INSURANCE PHONE NUMBER: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
WHO IS THE POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_

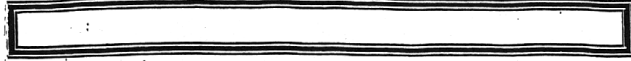
DO YOU HAVE A SECONDARY INSURANCE? YES OR NO  
IF YES ,THEN PRESENT TO FRONT DESK!

\*PHARMACY NAME AND ADDRESS : \_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF PARENT: \_\_\_\_\_ DATE: \_\_\_\_\_



# Beyond Care Pediatrics



5506 Broadway Blvd Garland, TX 75043  
Tele: 972-303-2400 Fax: 972-303-4343

## PAYMENT AGREEMENT

5506 BROADWAY BLVD, GARLAND, TX 75043  
OFFICE # (972) 303-2400 FAX # (972) 303-4343

*We appreciate and expect payment for services prior to each office visit.*

*If you have any questions about fees please feel free to ask.*

*The receipt form we give you at the end of the each visit contains all the information needed from the doctor for your insurance company to process your claim. Please remember that your insurance is considered a method of reimbursing you for fees paid. Questions regarding insurance matters should be discussed with your insurance company first. The insurance company's agreement to pay for medical care is a contract between you and that company.*

*We accept assignment of benefits as a courtesy to our patients, but the insured is ultimately responsible for all expenses.*

*VISA and MasterCard are accepted at this office.*

*Please sign and date below. Thank You*

Name of person completing form \_\_\_\_\_

Signature \_\_\_\_\_ Relationship \_\_\_\_\_

Date \_\_\_\_\_



**BEYOND CARE PEDIATRICS  
5506 BROADWAY BLVD  
GARLAND, TX, 75043**



**PATIENT FINANCIAL RESPONSIBILITY & ACKNOWLEDGEMENT OF FEES**

- |  |         |
|--|---------|
| 1.) MEDICAL RECORDS FOR PERSONAL USE IS -<br>NO CHARGE FOR FAXING TO A PROVIDER                              | \$35.00 |
| 2.) PHYSICAL FORM (IF NOT PROVIDED DURING VISIT)-  | \$20.00 |
| 3.) IRS LETTER OR IMMIGRATION LETTERS-   | \$10.00 |
| 4.) COPY OF SHOT RECORD -<br>FOR FAXING NO CHARGE BUT WE NEED LETTER OF PERMISSION<br>TO RELEASE SHOT RECORD | \$10.00 |
| 5.) BOOK OF SHOT REORD -   | \$15.00 |

**PATIENT CONSENT TO TREAT MINOR CHILD**

I, \_\_\_\_\_ DO HEREBY CONSENT FOR MY  
(PARENT) OR (LEGAL GUARDIAN)  
CHILD \_\_\_\_\_ FOR DR KHAN, ZEESHAN, OR  
(CHILD FULL NAME)  
VICK, KATHLEEN NP OR DR ANWAR, KASHIF OR A  
COVERING PROVIDER TO TREAT YOUR CHILD .

I, \_\_\_\_\_ GIVE THE FOLLOWING PEOPLE  
(PARENT) OR (LEGAL GUARDIAN)  
AUTHORITY TO BRING MY CHILDREN TO BEYOND CARE  
PEDIATRICS CLINIC TO BE TREATED.

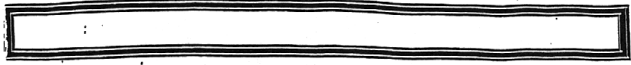
FULL NAME: \_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_

FULL NAME: \_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_

**SIGNATURE OF**  
**PARENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**LEGAL GUARDIAN**



# Beyond Care Pediatrics



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Nurse Practitioner | Physician Assistant Consent for Treatment

*Beyond Care* has Nurse Practitioners and Physician Assistants delivering primary medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training.

A Physician Assistant is not a doctor. A Physician Assistant (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician.

Nurse Practitioners and Physician Assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, monitor acute and chronic illnesses and write prescriptions. In addition, they may treat lacerations and other minor injuries, as well as perform other procedures.

I have read the above, and hereby consent to the services of Nurse Practitioner or Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician.

\_\_\_\_\_  
Patient Name Date of Birth

\_\_\_\_\_  
Patient Guardian Signature Date

Ortho/2017

TEXAS DEPARTMENT OF STATE HEALTH SERVICES  
 IMMUNIZATION REGISTRY (ImmTrac)  
 MINOR CONSENT FORM



(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth *\*Children under 18 years only.*

Child's Gender:  Male  Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

*The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.*

**Consent for Registration of Child and Release of Immunization Records to Authorized Entities**

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group - MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • [www.ImmTrac.com](http://www.ImmTrac.com)  
 Texas Department of State Health Services • ImmTrac Group - MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7  
 Revised 05/13/2012



**PROVIDERS REGISTERED WITH ImmTrac** - Please enter client information in ImmTrac and affirm that consent has been granted. **DO NOT** fax to ImmTrac. Retain this form in your client's record.

**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.

- Child's Name: \_\_\_\_\_  
Last Name First Name MI
- Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Parent/Guardian/Individual of Record: \_\_\_\_\_  
Last Name First Name MI BEYOND CARE PEDIATRICS  
 5506 BROADWAY BLVD.  
 GARLAND, TX 75043
- Primary Provider's Name: \_\_\_\_\_  
Last Name First Name MI ANWAR KASHIF, M.D.
- 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.

Date	Eligibility for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*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.







# BEYOND CARE PEDIATRICS PLLC



5506 BROADWAY BLVD  
GARLAND TX 75043  
PHONE:972-303-2400 FAX:972-303-4343

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
BEYOND CARE PEDIATRICS, PLLC THE HIPAA PRIVACY RULE  
(45 CFR 164.520)**

*I, name of parent \_\_\_\_\_ acknowledge and agree that I have received  
a copy of PRIVACY PRACTICES OF DR KHAN ZEESHAN AND DR ANWAR, KASHIF*

CHILD NAME (PATIENT) \_\_\_\_\_ DATE : \_\_\_\_\_

PARENT NAME OR LEGAL  
REPRESENTATIVE \_\_\_\_\_

**NOTICE TO PATIENT OR LEGAL REPRESENTATIVE**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and /or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S  
NOTICE OF PRIVACY PRACTICES.(HIPPA)**

*FOR CLINIC USE ONLY:  
HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE AND COVERS ONLY  
FEDERAL, NOT STATE LAW*