Calcasieu Parish School Board

BUILDING FOUNDATIONS FOR THE FUTURE

Shannon LaFargue, PhD, Superintendent

VERIFICATION OF SERVICES FORM

SECTION 1: PATIENT INFORMATION (*PATIENT*- Please print)

First Name Middle Initial Last Name

Street Address City State Zip Code

( ) - Age: ☐ ☐ Date of Birth:

Primary Phone Number Male Female Month Day Year

Patient Disclosure Statement: I understand that verification data will be submitted to CPSB's Wellness Program in the Risk Management Department for incentive purposes. All information will remain confidential and will be protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I am voluntarily participating in CPSB's Wellness Program.

____ _______________________

Patient Signature Date

In order to receive credit, services must be completed between May 1, 2023 and April 30, 2024.

SECTION 2: SERVICES RENDERED

*****Verification of Services*****

The patient named above was seen in my office on ______________________ for the following service(s) (please check:)

☐	Flu shot/vaccine	☐	Annual Blood Work	☐	Prostate Exam
☐	Shingles shot/vaccine	☐	Wellness / Physical Exam	☐	Colonoscopy
☐	Pneumonia shot/vaccine	☐	Mammogram	☐	Eye Exam / Dental Exam (circle one)

SECTION 3: PHYSICIAN INFORMATION

Provider's Name ____ Phone Number:( ) - ________

(Please Print) First Last

____

Street Address City State Zip Code

PHYSICIAN'S SIGNATURE (req'd) DATE

****One form per date of service**