LVPG DIABETES & ENDOCRINOLOGY

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Practice Locations

1243 S. Cedar Crest Blvd., Suite 2800
Allentown, PA 18103
610-402-6790 phone
610-402-6799 fax

2663 Schoenersville Rd.
Bethlehem, PA 18017
484-895-4440 phone
484-895-4460 fax

Health Center at Quakertown
99 West End Blvd., Suite 105
Quakertown, PA 18951
215-538-7193 phone

Welcome to our practice. To partner with you to provide quality healthcare, here are some key points to better acquaint you with our practice and to provide you with an optimum visit.

Check List for items to bring with you

- ☐ Attached forms completed.
- ☐ Insurance Card(s)
- ☐ Insurance referral if required by your insurance
- ☐ Photo ID (i.e. driver's license, passport, state ID)
- ☐ Current list of medications, doses, and frequency.
- ☐ Co-payment if required by your insurance- cash, personal check, Master Card, VISA, Discover, American Express and most flex spend cards are accepted.

Let's make your visit the best it can be!

- FREE parking at all locations, including the parking deck at the Allentown location.
- If there are any changes to your insurance, please call us as soon as possible so we can check if we participate with your new insurance.
- Contact your family doctor at least three (3) days prior to your appointment for an insurance referral if your insurance requires one.
- Can't keep your appointment? Please call our office as soon as possible to reschedule or cancel your appointment. It may be necessary to reschedule your appointment if you arrive more than 10 minutes late.
- Normal office hours are Monday through Friday, 8:00 A.M. to 5:00 P.M

What to expect at the time of your visit?

1. Upon arrival please check in with the receptionist at the front desk before taking a seat.
2. The nursing staff will bring you to an exam room and the information you provide on the attached forms will be reviewed.
3. Your doctor or nurse practitioner will then see you to review your information and discuss the reason for your visit.
4. There will not be any labs drawn at the time of your visit.

Thank you for choosing LVPG Diabetes and Endocrinology for your health care needs.
We look forward to partnering in your care!

LVPG Medical Information Communication Preferences

PLEASE RETURN THIS FORM TO THE RECEPTIONIST
PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MI_____

ADDRESS _____

CITY_____STATE_____ZIP_____EMAIL _____

HOME PHONE_____OTHER PHONE_____☐MALE ☐ FEMALE

DATE OF BIRTH_____ MARITAL STATUS _____ SS#_____

INSURANCE PRIMARY SECONDARY

NAME _____ _____

GROUP # _____ _____

SUBSCRIBER _____ _____

EFFECTIVE DATE _____ _____

REFERRING DOCTOR INFORMATION

FAMILY DOCTOR_____PHONE NUMBER_____

REFERRING DOCTOR_____PHONE NUMBER_____

EMPLOYER INFORMATION

PATIENT EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____PHONE NUMBER_____

SPOUSE INFORMATION

LAST NAME_____FIRST NAME_____MI_____

DATE OF BIRTH_____ SS#_____WORK NUMBER_____

EMPLOYER_____EMPLOYER ADDRESS_____

EMERGENCY CONTACT

NAME_____PHONE NUMBER_____ _____

RELATIONSHIP_____ NEXT OF KIN_____

IF PATIENT IS A MINOR

MOTHER'S NAME_____SS#_____DATE OF BIRTH_____

FATHER'S NAME_____SS#_____DATE OF BIRTH_____

LVPG Medical Information Communication Preferences

Patient _____ MR#_____ DOB ____/___/____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

❑ I give permission to **leave medical information** pertaining **to me, my dependent or child**, at the numbers listed below:

Method	Yes	No	Area Code, Phone #, Ext, E-MAIL
Home telephone			
Answering Machine			
Work Phone			
Cell Phone			
E-MAIL for our Patient Portal secure email registration			
E-MAIL to receive provider-ordered online patient education programs			
Pager			

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

❑ Do **not release medical information** to anyone other than myself.

❑ I give **permission to release medical information** pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____(Please Print Signer's Name)

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS

PATIENT:		DOB:	MEDICAL RECORD #:
DATE:	TIME:	LOCATION: **LVPG – Diabetes and Endocrinology**	

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize LVPG (Lehigh Valley Physician Group), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Lehigh Valley Health Network & the Common Medical Staff of Lehigh Valley Hospital & Lehigh Valley Hospital-Muhlenberg on or after 04/14/03.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the LVPG provider of service(s) furnished to me. I authorize LVPG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to LVPG. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through LVPG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an LVPG billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with LVPG's approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated LVPG and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

ELECTRONIC PRESCRIBING: I understand that LVPG medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my LVPG providers and my pharmacy. I have been informed and understand that LVPG providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my LVPG providers to see this health information.

IMMUNIZATION REGISTRY: I understand that LVPG participates in the Pennsylvania Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all LVPG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an LVPG medical practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for LVPG to send or fax childhood immunization records to schools, upon request.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Representative | Relationship to Patient if Applicable

_____ _____

Witness to Signature | Date of Signing