Lehigh Valley Peds

## PATIENT INFORMATION

Date _____ Main Contact Phone # _____

Name of Child(ren) _____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Home Address _____

City, State, Zip Code _____

## PARENT/GUARDIAN INFORMATION

Father/Guardian

Last Name _____ Home # _____

First Name _____ Work # _____

Middle Name _____ Cell Phone # _____

Address _____ DOB _____

City/State _____ Social Security # _____

Zip Code _____ Employer Name _____

Employer Address _____

Email Address _____

Mother/Guardian

Last Name _____ Home # _____

First Name _____ Work # _____

Middle Name _____ Cell Phone # _____

Address _____ DOB _____

City/State _____ Social Security # _____

Zip Code _____ Employer Name _____

Employer Address _____

Email Address _____

## INSURANCE INFORMATION

Primary Plan _____ Name of Policy Holder _____

Policy Holder DOB _____

Policy Address _____ City/State/Zip _____

Policy/Member ID # _____ Group # _____

Secondary Plan _____ Name of Policy Holder _____

Policy Holder DOB _____

Policy Address _____ City/State/Zip _____

Policy/Member ID # _____ Group # _____

The information regarding my child(ren) on this patient demographic form is current and up-to-date. I understand that I will be responsible for any and all services denied by my insurance company due to any incorrect information on this form.

**Signature of Parent/Guardian** _____

Lehigh Valley Peds

PATIENT NAME _____ DOB _____

# FINANCIAL POLICY

## OUR PRACTICE FINANCIAL POLICY

Lehigh Valley Pediatrics is dedicated to providing your child(ren) with the best possible care and service, and regard your understanding of our financial policies as an essential element of their care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover, personal check or cash. You agree, in order for us to service your account or to collect monies you may owe, Lehigh Valley Pediatrics Associates, Inc. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Please note that if your account becomes delinquent and is placed with our collection agency, you may be assessed a collection fee which may be added to your outstanding balance by the agency.

## YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayments at the time of service. The copayment will be collected before services are rendered. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, charges for care and treatment are due at the time of service.

We will also bill health plans for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

## MINOR PATIENTS

For all services rendered to a minor patient, the adult accompanying the patient is responsible for payment unless a court order states otherwise.

***I have read and understand the financial policy of this practice. I also understand and agree that such terms may be amended from time to time by the practice.***

_____ _____

Signature of patient or responsible party if a minor Date

Lehigh Valley Peds

# CONSENT TO TREATMENT
# RECORD RELEASE
# & PAYMENT AUTHORIZATION FORM

**CONSENT TO TREATMENT**

I hereby consent for my child to receive treatment by the physicians or designates of Lehigh Valley Pediatric Associates, Inc. I also consent for treatment for my child should he/she be presented by a representative of my family, guardian, babysitter, etc. at the time of the appointed visit.

**RECORD INFORMATION RELEASE**

I AUTHORIZE Lehigh Valley Pediatric Associates, Inc. to release any/or all records to those individuals or organizations designated appropriate for acceptance and utilization of such information for my child.

**PAYMENT AUTHORIZATION**

I hereby authorize my medical insurance to make payment directly to Lehigh Valley Pediatric Associates, Inc. I hereby affirm that all payments made directly to me for services provided by Lehigh Valley Pediatric Associates, Inc. will be forwarded to their office upon receipt.

***I understand I am financially responsible for all charges not covered by my insurance carrier for the care and treatment of my child.***

_____ _____

Signature of Parent/Guardian of Minor Child | Date

_____ _____

Patient Name | Date of Birth

# COMBINED ACKNOWLEDGEMENT AND CONSENT

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

**Patient(s)' Name:** _____

**Read before signing the Acknowledgement and Consent**

This acknowledgement of notice and consent authorizes Lehigh Valley Pediatric Associates, Inc. to use and disclose health information about your child for treatment, payment, and healthcare operations purposes.

**Notice of Privacy Practices.** Lehigh Valley Pediatric Associates, Inc. has a Notice of Privacy Practices, which describes how we may use and disclose your child's protected health information and how you can access your child's protected health information and exercise other rights concerning your child's protected health information. You may review our current notice prior to signing this acknowledgement and consent.

**Amendments.** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**How to contact our Privacy Officer**

Mail: Lehigh Valley Pediatric Associates, Inc.
1251 S. Cedar Crest Blvd. • Suite 109 • Allentown, PA 18103
Attention: Privacy Officer
Telephone: (610) 434-2162
Facsimile: (610) 434-9370

**Acknowledgement and Consent**

Print or type all information except signature.

I have received the Notice of Privacy Practices for Lehigh Valley Pediatric Associates, Inc. and authorize them to use and disclose health information about

_____(patient's names)

for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of patient (or patient's personal representative) Date

Personal representative information (if applicable):

_____ _____

Name of personal representative Relationship to patient (or other authority)

Lehigh Valley Pediatric Associates, Inc.

## Patient Communication Permission

Patient Name: _____ SSN: _____ DOB: _____

Patient Name: _____ SSN: _____ DOB: _____

Patient Name: _____ SSN: _____ DOB: _____

Patient Name: _____ SSN: _____ DOB: _____

As a parent of a patient in our practice, from time to time we may need to communicate with you when you are not in the practice. To preserve your child's privacy, we would like you to indicate your preferred method for us to communicate information to you.

Without specific permission we will not release any of your child's medical or billing information to another person. In some cases you may wish for another person to have access to your child's medical information.

In the event that no one is available to answer your phone, we need permission to leave certain types of information on your answering machine or with another person. Please indicate **your preference** by checking one or more of the boxes below.

- ❑ Do not leave medical information on an answering machine or with another person.
- ❑ I give permission for Lehigh Valley Pediatric Assoc., Inc. personnel to leave any and all medical information pertaining to my child, including appointment reminders, on my home answering machine at the number listed below:

  Phone Number: _____
- ❑ I give permission to Lehigh Valley Pediatric Assoc., Inc. personnel to give any and all medical information pertaining to my child, including appointment reminders, to the individual listed below:

  Name: _____
- ❑ I give permission for Lehigh Valley Pediatric Assoc., Inc. personnel to discuss my child's account balance, insurance coverage/benefits, payment plans, payments, and history of my child's account to the individual listed below:

  Name: _____

**I assume responsibility to inform the practice of changes in my phone number(s), person to discuss my child's medical and billing information, or my preference.**

_____
**Parent/Guardian Name**

_____ _____
**Signature** **Date**

_____
**Witness**

# Lehigh Valley Peds
## Child and Family History

Child's Name _____ Date of Birth _____

Medication Allergies _____ Other Allergies _____

Serious Illness/Hospitalization/Surgery (include date) _____

_____

Any specialists your child sees or has seen _____

Delivery: ☐ Vaginal ☐ C-section Birthweight _____ Was your child more than 2 weeks: ☐ Early ☐ Late ☐ Breastfed?

**Please check off all that apply for your child:**

- ☐ convulsions/epilepsy
- ☐ concussion/head injury
- ☐ severe headaches
- ☐ febrile seizures
- ☐ eye problems
- ☐ chronic ear infections
- ☐ hearing problems
- ☐ ear tubes and date(s) _____
- ☐ many sore throats
- ☐ allergies
- ☐ asthma/wheezing
- ☐ heart murmur
- ☐ jaundice
- ☐ skin problems/eczema
- ☐ feeding problems
- ☐ bowel problems
- ☐ any surgery
- ☐ weight problems
- ☐ kidney/bladder/urinary
- ☐ broken bones
- ☐ sports injuries
- ☐ sleep problems
- ☐ speech problems
- ☐ school/learning problems
- ☐ developmental problems
- ☐ emotional problems
- ☐ discipline problems
- ☐ handicaps/disabilities
- ☐ high cholesterol
- ☐ vitamins
- ☐ fluoride supplements

_____

**Describe any positives:** _____

_____

**Please check off all that apply for your family; indicate their relationship to your child:**

- ☐ migraine/headache _____
- ☐ epilepsy/seizures _____
- ☐ glaucoma _____
- ☐ cataracts _____
- ☐ strabismus _____
- ☐ eye tumor _____
- ☐ eye/retinal cancer _____
- ☐ thyroid disorder _____
- ☐ diabetes _____
- ☐ cystic fibrosis _____
- ☐ allergies _____
- ☐ asthma _____
- ☐ TB/lung disease _____
- ☐ stroke _____
- ☐ obesity _____
- ☐ high blood pressure _____
- ☐ heart attack/ coronary artery disease _____
- ☐ heart murmurs _____
- ☐ high cholesterol _____
- ☐ kidney/urinary problems _____
- ☐ kidney cancer _____
- ☐ leukemia _____
- ☐ lymphoma _____
- ☐ colon cancer _____
- ☐ gall bladder _____
- ☐ inflammatory bowel _____
- ☐ irritable bowel _____
- ☐ hepatitis (if yes A, B or C) _____
- ☐ abnormal bleeding _____
- ☐ sickle cell anemia _____
- ☐ hip problems _____
- ☐ scoliosis _____
- ☐ arthritis/muscle disease _____
- ☐ mental retardation _____
- ☐ G6PD deficiency _____
- ☐ Marfan's disease _____
- ☐ SIDS _____
- ☐ alcoholism/addictions _____
- ☐ AIDS/HIV positive _____
- ☐ **cigarette smokers living in the home** _____
- ☐ any other cancer _____

**Describe any positives:** _____

_____

_____

Parent/Guardian _____ Date _____

Provider Review _____ Date _____