Lehigh Valley Family Practice Associates

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Phone 610-694-9090 *Fax* 610-861-8295

James W. Manley, DO **Eric D. Kane, DO** **Nikki Hrycko, CRNP** **Lynn Phillips, CRNP**

Patient Name _____ **Date of Birth** _____

Address _____

SSN _____ - _____ - _____ *(optional; last 4 digits requested)*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for **Lehigh Valley Family Practice Associates**, or that I have been notified that a copy will be provided upon my request.

PATIENT CONTACT INFORMATION and COMMUNICATION PREFERENCES

As a patient of our practice, from time to time we may need to communicate with you outside of your office visit. To preserve your privacy, please indicate your preferred method for us to communicate medical information to you and to others involved in your care. An example of this medical information is your test results.

Please provide the best number at which to reach **you**. Please indicate whether or not we may leave a detailed message.

Home _____ Message allowed? Yes/No Contact Preference 1st/2nd/ 3rd

Cell _____ Message allowed? Yes/No Contact Preference 1st/2nd/ 3rd

Other _____ Message allowed? Yes/No Contact Preference 1st/2nd/ 3rd

Without specific permission, we will not release any of your medical information to another person. 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, etc.).

Name _____ Relationship _____ Phone _____

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PATIENT PAYMENT AGREEMENT

You are responsible for deductibles, co-pays, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company. Please pay co-payments as services are rendered. The remaining balance should be taken care of within one (1) month of notice from billing service. If you, or your insurance carrier, make a payment exceeding your balance, reimbursement will be remitted.

Signature of Patient or Representative _____ **Relationship to Patient** _____

Printed Name of Signee _____ **Date** _____