ADULT MEDICINE AND GERIATRICS
798 HAUSMAN ROAD SUITE 270
ALLENTOWN PA 18104
FAX 484-403-4005 WEBSITE www.matlv.com

Thomas Brandecker, MD FACP
(610) 871-2800
Diplomat, American Board of Internal Medicine,
Geriatric Medicine

Lisa Cross, CRNP
(610) 871-3400

# NEW PATIENT INFORMATION

PATIENT INFORMATION DATE: ____________________

Name ______________________________________________________

Date of Birth ________________ Gender ____________________ Race ____________________________________

Address ________________________________________ City _____________________ State __________ Zip _______

Home Phone ______________________ Day Phone ________________ Cell Phone ______________________

Last 4 digits of Social Security # ____________ Marital Status M S W D Email ______________________________

Name of Emergency Contact ___________________________________________________________________________

Emergency Contact Phone # _________________________________ Relationship ______________________________

May we leave a message on your voicemail? Yes No

May we speak to another person regarding your condition? Yes No

Name of Person _____________________________________ Phone number ___________________________________

Name of Person _____________________________________ Phone number ___________________________________

**ALLEGIES TO MEDICATIONS** _________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**PATIENT EMPLOYER INFORMATION**

Employer Name ______________________________________ Phone # _______________________________________

Address _____________________________________________ Occupation ____________________________________

SPOUSES INFORMATION:

Spouses name: ______________________________ Date of birth: ______________

Employer name and address: ______________________________________________

______________________________________ Phone # ______________________

INSURANCE INFORMATION: PRESCRIPTION PLAN? YES NO

Name of Primary Insurance: ______________________________ Copay $ __________

Subscriber's Name: ____________________________________ Subscribers DOB ______

Insurance ID # ______________________ Insurance Group # ______________________

Name of Secondary Insurance: ____________________________ Copay $ __________

Subscriber Name : _____________________________________ Subscribers DOB ______

Insurance ID # ______________________ Insurance Group # ______________________

RESPONSIBLE PARTY:

Please complete the section below if someone other than the patient is responsible for the bill:

Name: ______________________ Address: ______________________________

Phone # ____________________ Relationship to patient ____________________

Employer Name and Address: ______________________________________________

__________________________ Employer phone # ____________________________

The signature below authorizes the release of any medical information necessary to process any claims submitted. I also request payment of the benefits to be made to Medical Associates of the Lehigh Valley, PC, for any services rendered to my by any or all MATLV providers.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. This includes co-insurances, non-covered services, "less amounts that exceed maximum coverage", copayments, deductibles, etc.

Payments of office visit (s) is due at the time of service, except for Medicare patients and for those insurances with which this office has contractual agreement. COPAYS ARE DUE AT THE TIME OF SERVICE.

I authorize any holder of medical information about me to release to my current medical insurance company, including Centers of Medicare and Medicaid Services or its agents, any information needed to determine these benefits or the benefits payable for related services of the HIC/Policy number written on this form.

In addition, I request that payments of authorized Medicare of my insurance benefits be made/assigned on my behalf to Medical Associates of the Lehigh Valley, PC.

**FOR MEDICARE PATIENTS ONLY:** I request the payments of Medigap Benefits (secondary co-insurance) as noted on this form, be made to Medical Associates of the Lehigh Valley, PC, for any services rendered to me by any MATLV provider.

I have read all of the information and I certify that this information is true and correct to the best of my knowledge. I will notify your office of any changes in the above information.

**PATIENT SIGNATURE OR AUTHORIZED PERSON:** ____________________________________________

Date _____/_____/______ (Completion of the form and signature required)

I have reviewed my Patient Information sheet and agree that there are no changes from previous year.

Signature____________________________________________________Date ______________

Signature ____________________________________________________Date ______________

Signature ____________________________________________________Date ______________

Signature ____________________________________________________Date ______________

Signature ____________________________________________________Date ______________

Signature ____________________________________________________Date ______________

*Preserving the Patient-Doctor Relationship*

# PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how Medical Associates of the Lehigh Valley (the "Practice") may use and disclose protected health information ("PHI") about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgment form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge that our Practice may use and disclosure PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI but the Practice does not have to agree to those restrictions.

This Acknowledgment is signed by:______________________________________________

Date:_______________________________

Relationship to Patient (if other than patient):___________________________________

Name of Patient (if signed by other than patient):_________________________________

Witnessed by:_________________________________________
Signature of Practice Representative

## FINANCIAL POLICY

The purpose of this Financial Policy is to help understand our billing and payment policies for our professional services. We ask that you read and acknowledge the following with your signature.

- All patients should provide accurate and complete personal demographics and insurance information prior to being seen by the provider. All insurance cards **should be** shown at each and every visit.
- All applicable co-payments and balances, both current and prior, are due at the time of service.
- We accept cash, check, Visa, MasterCard, American Express and Discover credit cards.

### *Regarding Insurance*

Our practice participates with many health insurance companies. It is your responsibility to comply with any predetermination of benefits or referral requirements. Please be aware that some or all of the services provided may be non-covered by your insurance company. Our billing department will submit a claim to the insurance company on your behalf. If you are a member of an insurance company that we do not participate in, we will request payment in full at the time of service.

If your plan assigns a PCP (primary care physician) to you and we are **not** your PCP, we will not file a claim with the insurance company (i.e. HMO).

You are responsible for contacting our office to request a referral or authorization required by your insurance company. This request should be submitted within 72 hours prior to the date of the office visit or procedure because of the processing time needed to obtain a referral or authorization. We must participate with your insurance company to obtain a referral or an authorization.

In the event of personal financial hardship, Medical Associates of the Lehigh Valley, PC can offer special financial arrangements, including payment plans. Financial documents could be requested for any financial hardship.

### *Billing Statements*

A billing statement for any balance due for services rendered will be sent to you on a monthly basis. If you cannot pay the balance in full, please contact our billing department to make payment arrangements (610-973-1410).

### *Returned Checks*

If a personal check is returned from your bank for any reason, your account will be charged a **$20.00** return check fee.

***Past Due Accounts***
Accounts that are past due **could be referred** to our Collection Agency.

***Children Accounts***
For a child under 18, the accompanying parent or guardian of a child is responsible for payment according to terms described above. We will not get involved in any custody arrangements for payment.

***Completion of Forms***
Please be aware that your physician reserves the right to charge a fee when requesting the completion of forms at a time other than your office visit.

***Copying Medical Records***
We reserve the right to charge a medical records copying fee in accordance with Act 26. We do not seek to make a profit on providing medical records, rather to recover our costs for copying them.

I authorize and assign insurance benefit payments directly to LVPG MATLV for any medical services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered that is not covered by my insurance company.

I have read the Financial Policy. I understand and agree to the Financial Policy.

________________________________________
Print Name

________________________________________
Signature

________________________________________
Date

Patient Name ______________________________________
Date of Birth ______________________________________

## FAMILY HISTORY

Please list any family member which have been affected by the following illnesses:

| | FAMILY MEMBER |
|---|---|
| Cancer (what type?) | ______________________ |
| Diabetes | ______________________ |
| Heart Disease | ______________________ |
| Heart Attack | ______________________ |
| Stroke | ______________________ |
| Seizures | ______________________ |
| Dementia | ______________________ |
| Hypertension | ______________________ |

## SOCIAL HISTORY

Marital Status M D W S
Children? Y N Boys ________ Girls _________
Do you live alone? _____ If not, who lives with you? _________________
Do you consume caffeine? Y N Coffee Tea Soda Chocolate
Amount daily? _________
Do you smoke? Y N Number of packs per day _______
Do you drink alcohol? Y N What type _______ How often ________
What is/was your occupation? ____________________________________
Employment Status: full time part time retired unemployed
Do you exercise? Y N Type? ____________ Frequency _________
Do you wear seatbelts? Y N
Do you have a smoke detector in your home? Y N Carbon monoxide detector? Y N
Are there firearms in your home? Y N
Has your home been tested for Radon? Y N Positive Negative Treated? Y N
What type of home heating do you have? _______________

## ADVANCED DIRECTIVES

None Living Will Durable Power of Attorney HC proxy

Patient Name________________________________
Date of birth ________________________________

## PHARMACY

What Pharmacy do you use?
Local: ______________________Address______________________Phone:__________________
Mail away:____________________Address:____________________________________________

ALLERGIES:_______________________________________________________________________

## MEDICATIONS

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

## PAST MEDICAL/SURGICAL HISTORY

| List any surgeries you have had in the past: | Name of Surgeon |
|---|---|
| _________________________________ | ___________________________ |
| _________________________________ | ___________________________ |
| _________________________________ | ___________________________ |
| _________________________________ | ___________________________ |

List name of any other specialists (including eye doctor and dentist) you see and for what condition:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

When was your last:

Shingles shot ____________
Tetanus shot _____________
Flu Shot ________________
Pneumonia _______________
Mammogram_______________
GYN visit ________________
Colonoscopy ______________
PSA_____________________

How often do you see:

Dentist__________
Eye Doctor________