**Name: DOB: MR:**

## Vaccine History

To enable us to serve you to the best of our ability please fill out this brief vaccine history form. Also if you have a record of your immunizations please bring it along with you to your appointment.

| | | | |
|---|---|---|---|
| Hepatitis A | yes | no | Dates: ____________ |
| Hepatitis B | yes | no | Dates: ____________ |
| Twinrex (Hep. A. & Hep B.) | yes | no | Dates: ____________ |
| Herpes Zoster (Shingles) | yes | no | Dates: ____________ |
| HIB | yes | no | Dates: ____________ |
| Japanese Encephalitis | yes | no | Dates: ____________ |
| Meningococcal: | yes | no | Dates: ____________ |
| MMR (measles, mumps, rubella) | yes | no | Dates: ____________ |
| Polio | yes | no | Dates: ____________ |
| Tetanus | yes | no | Dates: ____________ |
| Typhoid | yes | no | Dates: ____________ |
| Varicella (chicken pox)` | yes | no | Dates: ____________ |
| Yellow Fever | yes | no | Dates: ____________ |

Flu shot this year? yes no Dates: ____________

If yes: ☐ Inactivated ☐ Live Attenuated Nasal

# 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 PHYSICIAN GROUP
# MEMBER FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT FORM

The undersigned member of ______________________________ agrees to be financially
(HEALTH INSURANCE PLAN)

responsible for and pay to **Keystone Travel Medicine (LVPG Travel Med)** the amount of the charges for service(s) not covered by the above mentioned Health Insurance Plan.

**PLEASE LIST THE NON-COVERED SERVICE BELOW,**
**ALONG WITH REASON AND ESTIMATED COST: ALL 3 BOXES MUST BE COMPLETED.**

| NON-COVERED SERVICE | REASON INSURANCE MAY NOT PAY | ESTIMATED COST |
|---|---|---|
| **A description of the service must be entered:**<br>☐ Travel Consult<br>☐ Travel Vaccines: Vaccine administration fees (each vaccine will carry an individual administration fee) | ☐ Service that is a non-covered benefit<br>☐ Services may be subject to plan limitations<br>☐ Services the plan has deemed not medically necessary<br>☐ Services that require prior Authorization<br>☐ HCB09 MA—Medicare Part D drugs not covered by MA<br>☐ HCB15 MA-Select Plan for Families-family planning only<br>☐ Other ______________________ | ☐ $70-$99<br>☐ $25- $295/per vaccine dose – admin fee not included<br>☐ $15-$45/ per vaccine |

**I have read this form and understand its contents.**

______________________ ______________ ______________________

PATIENT NAME (printed) DOB MRN or GUARANTOR NUMBER

______________________ ______________

PATIENT SIGNATURE DATE

**In the event the Member who will receive these services is a minor, the undersigned parent/guardian of that minor, agrees to be financially liable for services described above.**

______________________ ______________ ______________

SIGNATURE OF PARENT, GUARDIAN OR LEGAL REPRESENTATIVE DATE WITNESS

Lehigh Valley Health Network

A. Notifier:

B. Patient Name: C. Identification Number:

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| **Travel Consult**<br>**Travel Vaccines**<br>**Vaccine administration fees (each vaccine will carry an individual administration fee)** | **Non-compensable services/ Not a Medicare Benefit** | **$70-$99**<br>**$25- $295/per vaccine dose- admin fee not included**<br>**$15-$45/ per vaccine** |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.

  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.