Lehigh Valley Health Network

LVPG Family Medicine–Muhlenberg College
- 2400 Chew Street, Allentown, PA 18104
- Tel: 484-664-3199 Fax: 484-664-3522

Please complete this health form packet in its entirety and upload all pages and your insurance card as a single file to: https://webxfer.lvh.com/form/studenthealth#/

Section 1: Demographic Information

Legal Name _____ Date of Birth _____

Preferred Name: _____ Pronouns: _____ Sex Assigned at Birth: _____ Gender Identity: _____

Home Address _____

Cell Phone Number: _____

Section 2: Emergency Contact(s)

Name _____

Relationship to Student _____

Contact Phone Number: _____

Name _____

Relationship to Student _____

Contact Phone Number: _____

Section 3: Health Insurance

Visits to LVPG Family Medicine–Muhlenberg College are billed to insurance.

Insurance Company Name: _____

Insurance Company Address: _____

Policy Holder/Subscriber Name _____ Policy Holder Date of Birth: _____

Policy or ID Number: _____ Group # _____

Preferred Lab for your insurance (please circle): Health Network Lab Quest LabCorp

☐ **Insurance card copy (front and back) must be included when submitting your health form.**

Name _____ Date of Birth _____

Section 4: Personal Medical History

Please check if you currently have or had a history of conditions listed below. Explain "yes" answers.

Yes	No	Condition	Explanation
		Neurologic: headaches. migraines, seizure, history of concussion, other	
		Lung Disease: asthma, recurrent bronchitis, pneumonia. tuberculosis. Other	
		Heart/Cardiovascular: high blood pressure, murmurs, congenital defects, POTS, syncope, other	
		Intestinal: Crohn's, ulcerative colitis, irritable bowel syndrome, peptic ulcer disease, gastroesophageal reflux, dietary sensitivities	
		Endocrine Disorder: thyroid conditions, diabetes, other	
		Hematologic: anemia, clotting disorder, sickle cell, other	
		Rheumatologic: systemic lupus erythematous, rheumatoid arthritis, other	
		High Cholesterol	
		Liver Disease: hepatitis, jaundice gallbladder disease, other	
		Orthopedic: joint or muscle conditions, arthritis, major injuries, other	
		ENT: recurrent sinus infections, recurrent strep throat, ear infections, hearing deficits, other.	
		Eye Conditions	
		GYN: menstrual disorder, ovarian cysts, polycystic ovarian syndrome, other	
		Testicular Conditions	
		Sexually Transmitted Infection	
		Anxiety, depression, bipolar disorder, obsessive compulsive other, other	
		Eating Disorder	
		Autism Spectrum Disorder	
		ADD/ADHD	
		Cancer	
		Congenital abnormalities	
		Other?	
		Previous Surgeries	

Section 5: Family History

Yes	No	Condition	Family Member
		Heart/ Cardiovascular Condition - Specify:	
		Lung Disease – Specify:	
		Diabetes– Specify:	
		Hypertension– Specify:	
		Thyroid Disease– Specify:	
		Blood Clots– Specify:	
		Cancer– Specify:	
		Anxiety, Depression, Bipolar, other mental health condition– Specify:	
		Other– Specify:	

Name:_____ Date of Birth:_____

Section 6: Current Medications
Please list all current medications, including prescribed, over the counter, birth control, supplements. Include medication name, dose, and how often you take it. Attach separate sheet if needed.

Section 7: Allergies
Are you allergic to any **MEDICATIONS**? _____. If yes, please specify medication name and reaction _____ _____
Are you allergic to any **FOOD**? _____. If yes, please specify food and reaction _____ _____ *Note: We encourage you to also formally report your food allergy to Muhlenberg College's Office of Disability Services. This process will facilitate consultations and meetings with Muhlenberg College's Dining Services staff.*
Do you have any **ENVIRONMENTAL** allergies? _____. If yes, please specify and reaction _____ _____

Name:_____ Date of Birth:_____

Section 8: Create or Update your MyLVHN Chart online

To ensure a quick registration process, we encourage all students to have a "MyLVHN" chart. Please follow the steps below to update or create your MyLVHN chart.

Steps	Completed (Yes/No)
➢ Login to MyLVHN Students who already have a MyLVHN chart because they have accessed medical care previously by an LVHN provider do not need to create a new MyLVHN chart. If you have a MyChart account, login and proceed. If you do not have a MyChart account, create an account (Click "New user? Sign up now")	
➢ Add your Health Insurance information o Click on the three horizontal bars in upper left corner ("Your menu") o On the drop down menu, scroll down to "Insurance" o Click "Insurance Summary" o Click "Update Coverage" o Click "Add Coverage" on bottom of screen o Upload an image of your health insurance	
➢ Add your Personal Information o Click on the three horizontal bars in upper left corner ("Your menu") o On the drop down menu, scroll down to "Account Settings" o Click "Personal Information" o Complete the following sections: o Personal Information o Contact Information o Details about me o Family and Friends to contact in case of emergency	
➢ Complete your Communication Preferences Form o Click on the three horizontal bars in upper left corner ("Your menu") o In the search bar under "Your menu", search for "Communication Preferences" and complete	

Section 9: Complete other LVPG Forms

(links to these forms are on the Muhlenberg College Health Forms website)

	Completed (Yes/No)
➢ **Consent for Treatment Form** (all students must sign and parent/legal guardian must also sign if student is less than 18 years) ➢ **Medical Consent Authorization Minor** (parent/legal guardian must also sign if student is less than 18 years if student is less than 18 years) ➢ **Medical Information Communication Preference** ➢ **Authorization for LVPG to Release Protected Health Information to Muhlenberg College**	

PHYSICAL EXAM (to be completed by health care provider)

ALL STUDENTS: A physical exam is required within 12 months prior to the first day of class at Muhlenberg College.
VARSITY ATHLETES: A physical exam is required within 6 months prior to the start of fall practices at Muhlenberg College.

Student's Legal Name:_____ **DOB:**_____ **Preferred Name:** _____
Sex assigned at birth:_____ **Gender Identity:**_____**Pronouns:**_____ **Athletes – Sport:** _____

Section I: Physical Exam (Required)

Exam Date: _____ **Height** _____ **Weight:** _____**BMI:** _____ **B/P :**_____ **Pulse:**_____
Pupils: ❑**Equal** ❑**Unequal Vision: R 20/**_____ **L20/**_____ **Corrected:** ❑Yes ❑No

	NORMAL	ABNORMAL FINDINGS (describe) or COMMENTS
Skin		
Eyes/Ears/Hearing/Nose/Throat		
Respiratory/ Lungs		

Cardiovascular: Heart rhythm ❑ Normal ❑Abnormal

- Heart murmur ❑No ❑Yes If yes, specify: ❑ Systolic Murmur or ❑ Diastolic Murmur, Location_____ Grade (I-VI) _____
  Does murmur increase with Valsalva? ❑ No ❑Yes
- Pulses ❑ Normal ❑Abnormal. Any delay in femoral pulses? ❑ No ❑ Yes
- Marfan Criterias (Chest deformities, long arms and legs, wrist/joint hyperflexibility, flat footedness, scoliosis, lens dislocation, high arched palate, etc): ❑ No ❑Yes

Abnormal Findings or Comments:

Abdomen		
Genitourinary/Testicles/ Hernia		
Musculoskeletal		
Neurologic		# of Concussions:
Emotional		

Section II: Health History (Required. All questions must be answered. Attach additional sheet, if needed)

- Take any **medications**? If yes, please list med, dose, frequency. ( )**NO** ( )**YES** _____
- Any **allergies** (medicine, food, environmental)? ( )**NO** ( )**YES**, explain_____
- History of **Anaphylaxis**? ( )**NO** ( )**YES**, what was the trigger? _____ Carry an EpiPen or AuviQ? ( )NO ( )YES
- Have a loss or seriously impaired function of any paired organ? ( )**NO** ( )**YES**, explain _____
- **Medical & Surgical History** (include treatment for any medical or psychologic condition) _____
  _____
- Any **general comments or recommendations** that may be important for the care of this student
  _____

Section III: Tuberculosis Risk Assessment (Required) #1 and #2 must be answered, If Yes, PPD or IGRA required.

1. **Does the student have signs or symptoms of active tuberculosis disease?** ( )NO ( )YES, explain_____
   If YES, proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.
2. **Is the student a member of a high-risk group, or ever had close contact with persons known or suspected to have active TB disease, or lived in/visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa?** ( )NO ( )YES

***If Yes to #1 or #2 , IGRA or PPD (Mantoux) test required. Must complete below.**
Interferon Gamma Release Assay (IGRA) Date obtained:_____ Specify method: ❑QFT-GIT ❑T-Spot
Result: ❑ Positive ❑ Negative ❑ Indeterminant ❑Borderline (T-Spot only)

Tuberculin Skin Test (PPD) Date given (within the 6 months of college entrance) _____
Date Read _____ Result: _____ (mm of induration) ❑ Positive ❑ Negative

CHEST X-RAY REQUIRED (if tuberculin skin test or IGRA is positive). X-Ray result: ❑ Normal ❑ Abnormal Date: _____
Treatment (Include treatment and dates)_____

Section IV - Varsity Athletes only: Varsity Sports Clearance (must include EKG and Sickle Cell Trait Results)

❑Cleared without restriction ❑Cleared with restriction. Specify:_____
❑Not Cleared. Include reason:_____

Section V – Required for all students; health care provider information

Date: _____ **Health Care Provider Signature:**_____
Health Care Provider Name_____**Telephone:** _____

IMMUNIZATION RECORD (to be completed by health care provider)

Please record dates (month/day/year) below and include a copy of vaccine records from student's medical provider.

Student's Legal Name: _____ **Preferred Name**_____ **Date of Birth:** _____

Required Immunizations	1st Dose	2nd Dose	3rd Dose	4th Dose
Hepatitis B 3 dose series is required. A blood test (titers) showing immunity is acceptable (upload lab result).				
Meningitis Quadrivalent (Serogroup A,C,Y,W-135) Circle type: Menactra, Menveo, or MenQuadfi Or Penbraya (serotypes A.B,C,W and Y) At least one dose must be on or after age 16 years				
MMR (Measles/Mumps/Rubella) Two doses required at least 28 days apart after 12 months of age. Or blood tests showing immunity is acceptable (upload lab report).				
Varicella (chicken pox) 2 doses required				
Or **History of having the disease on this date** Or a blood test (titer) showing immunity is acceptable (upload lab report).	Date of disease			
Tdap Booster (Tetanus/Diphtheria/Pertussis) within past 10 years & on or after age 10 years				
Polio (OPV or IPV) Primary series of 3 or 4 doses in childhood				

Recommended Immunizations (not required)				
COVID-19 Primary Series and Booster(s) (Specify vaccine type in box)				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza (annually)				
Meningitis Serogroup B Circle type: Bexsero or Trumemba (serogroup B) Or Penbraya (serogroup A, B, C, W, and Y)				

I certify that to the best of my knowledge the information on the Immunization Record is true and complete.

Date: _____ Healthcare Provider Signature: _____

Healthcare Provider Name: _____

Address: _____

Telephone: _____ Fax: _____

AUTHORIZATION FOR LVPG TO RELEASE PROTECTED HEALTH INFORMATION TO MUHLENBERG COLLEGE

Section 1: Patient Information

Patient Name: _____

Social Security No. (last 4 digits): XXX-XX-_____ Date of Birth: _____

Address: _____ Telephone #_____

Section 2: Location of Care

Lehigh Valley Physician Group (LVPG) Family Medicine – Muhlenberg College
2400 Chew Street, Allentown, PA 18104
Tel: 484-664-3199 Fax: 484-664-3522

Section 3: Release Records to *(Where do you want us to send your medical records?)*:

I consent to and authorize LVPG to release information from my medical record from the above location(s) to:

Muhlenberg College
2400 Chew Street, Allentown, PA 18101

For the Purpose of determining compliance with Muhlenberg College health requirements.

Note: Information disclosed pursuant to this authorization may be submitted to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Information To Be Released:

- My completed Physical Exam form submitted to LVPG Family Medicine – Muhlenberg College
- My completed Immunization Record form submitted to LVPG Family Medicine – Muhlenberg College

Section 5: Authorization Signatures

This authorization is valid for 12 months from the date of signature on this request. I understand that this authorization may be revoked by me at any time by written notification to this facility except to the extent LVPG Family Medicine – Muhlenberg College has taken action in reliance on this authorization. If this request for medical records has already been completed, the authorization will remain on file. In addition, in order to process this request for reproduction of medical record information on a timely basis, LVPG Family Medicine – Muhlenberg College may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I have the right to request a copy of this authorization and I have the right to refuse to sign this authorization. A copy of this authorization is as valid as the original. **Electronic signatures will not be accepted.**

Patient Signature_____ Date Signed_____

Printed Name _____

Signature of Authorized Representative:_____ Date Signed_____

Printed Name of Authorized Representative: _____

Relationship: ☐ Parent or Legal Guardian ☐ Power of Attorney

Medical Information Communication Preferences

Patient _____ MR#_____ DOB ___/___/____

The information on this form will be utilized for all LVPG practices, LVHN clinics and outpatient departments, excluding behavioral health services.

As our patient, your care team is a partner in your healthcare. From time to time we may need to contact you about your care or treatment plan when you are not in the office/practice. To maintain your privacy and our partnership, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or to others involved in your care. Appointment reminder telephone calls or texts may be left at the telephone or cell phone number(s) you list below. Your responses and feedback about your healthcare experiences are important to us so that we can meet your expectations and continually improve as your healthcare partner. You may receive a survey by email, telephone or text to give us this feedback. If you choose not to receive a survey, you can decline at any time by replying to the survey request with an "opt out or decline" preference. Thank you.

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:

Home Phone_____
____ OK to leave message with details
____ Leave call back number only

Mobile Phone _____
____ OK to leave message with details
____ Leave call back number only

Work Phone_____
____ OK to leave message with details
____ Leave call back number only

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.):

☐ 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

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

I assume responsibility to inform the office/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 HOSPITAL
LEHIGH VALLEY HOSPITAL-HAZLETON
LEHIGH VALLEY HOSPITAL-POCONO
LEHIGH VALLEY HOSPITAL-SCHUYLKILL
LVHN SURGERY CENTER-TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
LEHIGH VALLEY PHYSICIAN GROUP (All Practices)
LVHN-EAST STROUDSBURG AMBULATORY SURGERY CENTER
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH ALLENTOWN
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH BETHLEHEM
LEHIGH VALLEY HEALTH NETWORK REHABILITATION CENTER-SCHUYLKILL
LVHN COORDINATED PROFESSIONAL PRACTICE (All Practices)

Name: _____

DoB: _____

LEHIGH VALLEY HEALTH NETWORK
CONSENT FOR TREATMENT

Please note that this consent applies to services rendered at, or rendered virtually by, the following Lehigh Valley Health Network (LVHN) entities: Lehigh Valley Hospital, LVHN Surgery Center-Tilghman, LVHN Children's Surgery Center, LVHN-East Stroudsburg Ambulatory Surgery Center, Lehigh Valley Hospital-Hazleton, Lehigh Valley Hospital-Pocono, Lehigh Valley Hospital- Schuylkill, Lehigh Valley Hospital-Coordinated Health Allentown, Lehigh Valley Hospital-Coordinated Health Bethlehem, Lehigh Valley Health Network Rehabilitation Center-Schuylkill, Lehigh Valley Physician Group and LVHN Coordinated Professional Practice and all its medical practices.

1.) **CONSENT FOR TREATMENT:** I grant authorization to LVHN and all its physicians and staff whether employed directly by LVHN or brought in on a consulting basis, for all such treatment and procedures as may be necessary for the patient herein named in accordance with the judgment of the medical provider. I understand that I am responsible for providing complete and accurate information concerning my medical history and current condition to my physician(s) and other health care providers. I understand that LVHN utilizes telehealth/ telemedicine technologies including digital photography, interactive audio and/or video, cloud-based storage and other types of secure HIPAA compliant technologies. Photographs, interactive video, and/or audio may be taken and/or utilized during my stay for treatment reasons or for monitoring my safety. Photographs may become part of my medical record, as appropriate. I acknowledge that no guarantees have been made as to the results of treatments or examinations in LVHN, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures or photographs to the extent permitted by law.

2.) **PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges incurred by and for the named patient from the date of admission/service, including services provided virtually. I agree to make payment in full immediately upon receipt of billings, whether interim or final billings. In the event that the undersigned fails to make payment as provided herein or agrees to alternate arrangements deemed satisfactory by LVHN, affirmative collection measures will be initiated. I agree to pay all costs of collection, including fifteen (15%) percent of the unpaid balance as a reasonable attorney's fees in the event that such indebtedness is turned over to an attorney for collection.

3.) **ASSIGNMENT OF BENEFITS:** In the event the undersigned is entitled to insurance benefits of any type out of any program health benefit plan or policy of insurance covering the patient or any other party liable to the patient, then such benefits are hereby assigned to LVHN and may be paid directly to LVHN. In the event benefits are paid, LVHN shall credit all payments to the patient's account; however, the patient and the undersigned, if not the patient, shall remain responsible for any portion of the LVHN bill not covered by this assignment. In the event that it is necessary to appeal an insurance payment decision, I authorize LVHN to appeal on my behalf.

4.) **INSURANCE COVERAGE NOTICE:** I acknowledge that LVHN will perform a search for active insurance coverage on all self-pay patients unless specifically requested otherwise with LVHN staff. This search will take place post-discharge, if named patient's bill remains unpaid for a defined period of time.

5.) **AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:** 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 Lehigh Valley Physician Group 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 treating 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.

6.) **HEALTH INFORMATION EXCHANGES:** LVHN may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *Care Everywhere*® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with an HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases. **IF YOU ARE NOT INTERESTED IN HAVING YOUR HEALTH INFORMATION SHARED WITH OTHER HEALTH CARE PROVIDERS IN THE HIE, PLEASE CHECK THIS BOX.** ☐

7.) **PRIVACY NOTICE:** I acknowledge receipt of the Health Information Privacy Notice for LVHN and the LVHN Medical Staffs on or after April 14, 2003, and as amended from time to time.

8.) **MEDICAL ASSISTANCE VERIFICATION:** I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL-HAZLETON
LEHIGH VALLEY HOSPITAL-POCONO
LEHIGH VALLEY HOSPITAL-SCHUYLKILL
LVHN SURGERY CENTER-TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
LEHIGH VALLEY PHYSICIAN GROUP (All Practices)
LVHN-EAST STROUDSBURG AMBULATORY SURGERY CENTER
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH ALLENTOWN
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH BETHLEHEM
LEHIGH VALLEY HEALTH NETWORK REHABILITATION CENTER-SCHUYLKILL
LVHN COORDINATED PROFESSIONAL PRACTICE (All Practices)

LEHIGH VALLEY HEALTH NETWORK CONSENT FOR TREATMENT

Name: _____

DOB: _____

9.) TELEPHONE CONSENT: I agree to allow LVHN, its agents, and vendors to use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the phone numbers that I provided and are on file (including wireless or cell phone numbers), and to leave voice mail messages at these phone numbers and include in any such messages information (including information required by law) about experience outreach and amounts I owe. IF YOU REFUSE TO PROVIDE TELEPHONE CONSENT, PLEASE CHECK THIS BOX. ☐ Please note that this provision does not affect the ability of LVHN providers to leave messages regarding appointment reminders or treatment information.

10.) ELECTRONIC PRESCRIBING: I understand that LVHN medical practices and offices may use an electronic prescription system which allows prescriptions and relates information to be electronically sent between my LVHN providers and my pharmacy. I have been informed and understand that LVHN 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 LVHN providers to see this health information.

11.) IMMUNIZATION REGISTRY: I understand that LVHN participates in the Pennsylvania Department 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.

<u>In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, LVHN Hospitals:</u>

AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION: As a patient, I have the option to be listed in the LVHN public information directory. If I elect not to be listed ("Do Not Announce") my presence will not be acknowledged and mail, telephone calls, flowers and visitors will be refused. Being listed in the public information directory means that your room number, telephone numbers and general condition can be released in matter of public record.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand and have been made aware that the Hospital provides facilities for the safekeeping of valuables. I release the Hospital from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in the patient's room, or at the bedside, including those valuables that may be brought to the patient by other persons.

DATA COMPILATION FOR RESEARCH: The undersigned hereby grants authorization for the Hospital to use a patient's health information for the internal purpose of gathering and sorting data (or human tissue) by categories to be available for potential use in research studies. If a patient's information is to be used for a research study, patient may be asked to sign additional authorization at that time.

PATIENT RIGHTS: I hereby acknowledge receipt of information regarding Patient Rights and the complaint process. I understand that I may contact the Department of Health at 800-254-5164 or the Joint Commission, Office of Quality & Patient Safety at: jointcommission.org/resources/patient-safety-topics report-a-patient-safety-event or Fax: 630-792-5636 if I want to report concerns about patient safety and quality of care. I understand that I may have a copy of the patient rights upon request.

<u>In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, Lehigh Valley Physician Group (LVPG) and LVHN Coordinated Professional Practice (LCPP) practices:</u>

LVHN EMPLOYEE IMMUNIZATION RELEASE: If you are employed by an LVHN subsidiary, I agree that vaccination documentation can be transmitted to LVHN Employee Health to facilitate any healthcare I may receive regarding occupational exposures or injuries and to verify that I meet vaccination requirements.

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

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

ACKNOWLEDGMENT FORM: I certify that I have read this document, that it has been fully explained to me if requested and that I understand its contents, and hereby agree to all terms and conditions set forth in the paragraphs above and acknowledge receipt of a copy if requested.

Signature of Patient	Date	Time
Signature of Authorized Agent / Representative	Date	Time
Relationship to Patient		
Witness	Date	Time

Lehigh Valley Physician Group
Medical Consent Authorization for Minor

(Giving permission for other person to bring my child to appointments and/or to make medical decisions for minor child on my behalf)

I, _____ am the PARENT of the child(ren) listed below. There are no court orders now in effect that would keep me from giving permission to another person (listed below) to make medical decisions (in other words, "medical consent") for my child.

—OR—

I, _____ am the LEGAL GUARDIAN or legal custodian of the children listed below (copy of court order attached, if available). There are no court orders now in effect that would keep me from giving permission to another person (listed below) to make medical decision (in other words, "medical consent) for this child.

I, _____, do hereby confer upon the following individual(s) the power to consent to medical or mental health treatment for the child(ren) listed below and on the child(ren)'s behalf do hereby state that the power to consent to which I confer shall not be affected by an subsequent disability or incapacity.

Individuals: *I give the following individuals permission to make medical decisions* (example: grandparents, siblings, etc.)

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

For Child(ren):

Name	Date of Birth	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- The power which I confer is specifically limited to health care and mental health care decision-making and it may be exercised only by the person's above.
- The person(s) named above may consent to the child(ren's) (cross out any that do NOT apply) ***medical, dental, surgical, developmental, and/or mental health*** examination and treatment. The person(s) named above may have access to any and all records, including, but not limited to insurance records regarding any such services.
- I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats, or payments by any person or agency. ***This document shall remain in effect until I notify the child(ren)'s medical, dental, mental healthcare and insurance providers and the person(s) named above in writing of my wish to revoke it.***

I, _____, have signed my name to this medical consent authorization, consisting of (1) page, on this _____ day of _____, 20____ in _____, PA.

_____ _____

Printed name (Parent, legal guardian/custodian) *Signature*

Witness No 1: Print name and Address: _____

Witness No 1: Signature _____

Witness No 2: Print name and Address: _____

Witness No 2: Signature _____

Signature(s) of person(s) authorized to consent on behalf of child(ren) named above (if available):

_____ _____

_____ _____