LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

David B. Vasily, M.D.
Michelle D. Ramsberger, PA-C
Sarah J. Hartman, PA-C
Lianne McGinn-Bunn, PA-C
Jenna Weidner, PA-C

940 North New Street
Bethlehem, PA 18018
(610) 866-2010
FAX (610) 866-4359

Dear New Patient,

Welcome to our practice. Although the following forms may see cumbersome, the information provided enables us to better understand your skin condition and possible relationship to your general medical health.

Simply do the best you can with these forms. Our assistants are available to assist you with specific questions when you are in the exam room.

Your appointment is very important to you and to us. During each day, we have a limited number of appointments available to accommodate all of our patients. If you are not able to keep your appointment, we require notice of at least 24 hours before your scheduled. ***If notice of cancellation is not given at least 24 hours in advance of your appointment, you will be charged a fee of $175.00.*** *The fee will be charged to the credit card you provided to reserve your appointment date and time. Payment of this fee is required before you are able to reschedule your appointment.*

Sincerely,

David B. Vasily, M.D.
Michelle D. Ramsberger, PA-C
Sarah J. Hartman, PA-C
Lianne McGinn-Bunn, PA-C
Jenna Weidner, PA-C

By signing below, you acknowledge notice of our cancellation policy and agree to abide by its terms.

______________________________ ______________
Patient Signature *Date*

LEHIGH VALLEY DERMATOLOGY associates, ltd.

Name: ____________________ DOB: __________ Date: __________

Email: ____________________ Last 4 digits of SS#: ______ Account #: __________

Address: City: Zip: Phone:

Do we have permission to leave a message on voicemail or with a family member: ☐ Yes ☐ No

Primary Care Physician: ____________________

Would you like a letter sent to them: ☐ Yes ☐ No

Past Medical History

☐ Anemia	☐ COPD	☐ Hypertension	☐ Persistent Cough/Cold
☐ Anxiety	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Post-Menopausal
☐ Arthritis	☐ Currently Pregnant	☐ Hypercholestolemia	☐ Prostate Cancer
☐ Asthma	☐ Depression	☐ Hyperthyroidism	☐ Psychiatric Treatment
☐ Atrial Fibrillation	☐ Diabetes	☐ Hypothyroidism	☐ Radiation Treatment
☐ Bloody Stool	☐ Dizziness/Fainting	☐ Hx Jaundice	☐ Recent weight loss
☐ Bone Marrow Transplant	☐ End Stage Renal Disease	☐ Hx Rheumatic Fever	☐ Ringing in Ears
☐ BPH	☐ Frequent Nose Bleeds	☐ Hx Tuberculosis	☐ Seizures
☐ Breast Cancer	☐ Fever/Chills	☐ Hx Ulcer	☐ Shortness of Breath
☐ Breast Feeding	☐ GERD	☐ Irregular Menses	☐ Sinus Problems
☐ Bruise Easily	☐ Glaucoma	☐ Leukemia	☐ Sore throat/Hoarseness
☐ Chemotherapy	☐ Hearing Loss	☐ Loss of Appetite	☐ Stroke
☐ Chest Pain/Discomfort	☐ Heart Attack	☐ Lung Cancer	☐ Swelling of Ankles
☐ Colon Cancer	☐ Heart Murmur	☐ Lymphoma	☐ Tire easily, weakness
☐ Convulsions/ Epilepsy	☐ Hepatitis	☐ Nipple Discharge	☐ Visual Changes

Other: ____________________

Surgical History

☐ Appendix ______	☐ Gallbladder ______	☐ Liver ______	☐ Rectum ______
☐ Bladder ______	☐ Heart ______	☐ Ovaries ______	☐ Skin ______
☐ Breast ______	☐ Joint Replacement ______	☐ Pancreas ______	☐ Testicles ______
☐ Colon ______	☐ Kidney ______	☐ Prostate ______	☐ Uterus ______

Other: ____________________

Skin Disease History

- ☐ Acne ____________
- ☐ Actinic Keratosis ____________
- ☐ Asthma ____________
- ☐ Basal Cell Carcinoma ____________
- ☐ Blistering Sunburns ____________
- ☐ Dry Skin ____________
- ☐ Eczema ____________
- ☐ Flaking/ Itching Scalp ____________
- ☐ Hay Fever/ Allergies ____________
- ☐ Melanoma ____________
- ☐ Poison Ivy ____________
- ☐ Precancerous Moles ____________
- ☐ Psoriasis ____________
- ☐ Squamous Cell Carcinoma ____________

Other: ____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF?____________

Number of blistering sunburns:________

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative? ____________________

List All Current Medications

Name:	Strength:	Dosage:	Frequency:

Local Pharmacy:____

Mail Order Pharmacy: ______________________________

Allergies (Medications/ latex/ epinephrine)

Name:	Reaction:

Social History

Smoking Status:

- ☐ Never
- ☐ Former
- ☐ Current # Packs per Day__________
  # Years Duration_________

EtOH:

- ☐ None
- ☐ Less than one drink per day
- ☐ One to two drinks per day
- ☐ More than three drinks per day

Occupation: ______________________________

Quality Measures

Have you received the influenza vaccine during influenza season? ☐ Yes ☐ No
Why not?______________

Patients 65 and older: Have you received the pneumonia vaccine? ☐ Yes ☐ No
Why not?______________

Do you have a advanced care plan? ☐ Yes ☐ No

Designee: ______________________________

Designee phone number: ______________________

Do you have a living will? ☐ Yes ☐ No

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History

History of:	Relationship:

Chief Complaint

Reason for today's visit. If you can, provide additional information about today's complaint including duration prior to

I have either read or been asked and replied to the above questions to the best of my knowledge. I have not omitted any other medical information from my history. I am aware that Lehigh Valley Dermatology Associates Limited are not responsible for medical evaluation of any complaints not related to my skin that have not been attended to by my personal medical physician or primary care physician. I agree to see my primary care physician for any medical conditions I am currently aware of or are detected during medical evaluation that are unrelated to my dermatologic condition.

Finally, I understand that providers encourage a complete skin exam and refusal to have this exam done could have deleterious effects on my health , including failure to detect skin cancer, melanoma, etc. I also understand that the skin is the largest organ of the body and that, it is impossible for providers to be responsible for examining every inch of skin covering my body.

Vitals:

Blood Pressure: __________ Pulse:_______ Respiration:_________

Completed by: __________ Patient

__________ Medical Assistant _________

Reviewed by Physician/ Physician Assistant: ______________________________ Date:_______________

Patient Signature:____ Date:_______________

Reviewed by: ____ Date:_______________

LEHIGH VALLEY DERMATOLOGY ASSOCIATES

940 N New Street

Bethlehem, PA 18018

Financial Policy, Referral/Pre-Authorization Policy & Credit Card Authorization

We thank you for choosing Lehigh Valley Dermatology Associates. We ask all of our patients to read and agree to our financial policy. We are happy to answer any questions you may have before you sign this. Unfortunately, patients who refuse to sign this are not able to be seen and may be subject to our appointment cancellation policy and fee.

We understand that healthcare and health insurance are very expensive, and we want you to receive the benefits and services from your insurance to which you are entitled. However, your insurance is a contract between you and your insurance company (and sometimes your employer). We have no control over what your specific insurance plan will cover and what they will not cover. In fact, it is not uncommon for insurance companies to cover something one month, and then decide not to cover it the next month. This is particularly true of non-Massachusetts-based insurances.

It has become increasingly time-consuming for our office to argue with insurance companies on your behalf to get them to pay your claim. If we have to spend time doing that, it means that other patients who need medical attention from us may not receive it. That "other" patient who needs us could one day be you or a family member. Therefore, any disputes on insurance claims will be your responsibility to dispute. We will provide you with any necessary documentation to aid you in this process.

All Co-pays, deductibles, co-insurances, self-pay or procedures not covered under insurance are due at the time of visit. Any remaining balance after insurance review will be your responsibility. Your signature on the next page IS your authorization to process any credit card or bank card payments you present to us to satisfy your account balance.

If you subscribe to an insurance plan which requires a referral or pre-authorization, that you have one on-file at the time of your visit. It is **YOUR** responsibility, not Lehigh Valley Dermatology's, although we are happy to assist you if we are able. The agreement and terms of coverage with your insurance company is between you and your insurance company. It is your responsibility to know is you need a referral or pre-authorization and to obtain one prior to your visit.

If a pre-authorization or referral is not obtained by you prior to your visit and your claim is denied, you will be responsible for the entire balance from your visit. Many insurance companies will deny your claim permanently if your referral is not authorized within 30-60 days.

Laboratory services (like bloodwork) and pathology services are performed by outside laboratories which are financially independent from our office. In the case of pathology services, we will send along all of the insurance information that you give us and the pathology lab will attempt to bill your insurance directly. However, there may be pathology services that your insurance will not cover. Feel free to discuss this directly with the pathology lab and/or your insurance company if you have questions.

If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 administrative fee if we are not able to run a new credit card within 7 days. This is comparable to the $25 fee that we charge for returned checks. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away.

Finally, when patients make appointments and then either "no show", or cancel them with less than one business days' notice, other patients who want to be seen as soon as possible, will not be seen. We do not double-book appointment slots, the time allotted to you goes unused and could have been given to someone else. Therefore, we reserve the right to charge for missed appointments in the range of $75-$165 per visit per patient when not cancelled more than one business day in advance.

LEHIGH VALLEY DERMATOLOGY ASSOCIATES

940 N New Street

Bethlehem, PA 18018

Accounts which are past due beyond 60-days are subject to a 1% per month interest charge. In addition, accounts which are more than 90days past due may be subject to an additional $35 processing fee, in addition to the interest charge, and may go to collections. If the account goes to collections, your national credit rating may be affected. Luckily it is extremely rare for an account to go to collections. We will make every effort to work with you to get your balance paid in full. Temporary financial set back can happen to anyone, and we are happy to privately and confidentially work out a payment plan with you that works for you and for us. Please feel free to discuss this with our manager(s). We do not want finances to ever come in the way of you or your family members from getting the best medical care possible!

Lehigh Valley Dermatology's primary purpose is to take care of patients and their families. That's it. We hope you now have a clear understanding of our financial policies. These policies exist for one reason only: so that we can concentrate on taking care of patients' medical needs, rather than dealing with insurance companies or trying to obtain balances for unpaid patient bills.

Pre-Authorized Healthcare Form

By signing below, I agree to Lehigh Valley Dermatology's Financial Policy, Referral/Pre-Authorization Policy, Cancellation Policy and Credit Card Authorization. I authorize LVD to charge my credit card/bank card that I present at the time of visit, over the phone or by mail for any outstanding balances. These may include: insurance denials for ANY reason (including no referral on file); missed or cancelled appointments; deductibles; co-insurances; partially paid claims; cosmetic procedures; as well as other reasons which may arise.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give LVD a new, valid credit card (in a timely manner) which I will allow them to key-in over the phone. Even though LVD is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed herewith and may be used with the same authorization as the original card which I presented in person. In addition, I agree not to initiate or pursue a chargeback or payment reversal after LVD has charged my credit card for any of the above reasons.

I understand that I am responsible for payment for all medical services provided to me by LVD. I understand that my insurance may deny or delay payment for these services or only partially pay my claim, and I agree to be financially responsible for any balance that is not covered by insurance or is considered my out-of-pocket portion. I understand that this form is valid until I cancel this authorization through written notice to LVD.

____ ____________________

Signature of Patient / Credit Card Holder (or Legal Guardian) Date

____________________________________ ____________________

Print Name of Person Signing Above Relationship to Patient

NO SHOW ATTESTATION POLICY

Due to an increasingly prevalent problem of no show follow up and new patient visits to our office, we are forced to implement our new no show policy as outlined below. The effect of these no show visits is that the medical costs, to our other compliant patients, are driven up and *valuable time slots are taken away from patients who need appointments.*

	DESCRIPTION	FEE	CONSEQUENCES
1.	No show number one	$25.00	Fee only
2.	No show number two (consecutive)	$25.00 first no show $50.00 second no show	Fee only
3.	No show number three (scattered or consecutive)	$25.00 first no show $50.00 second no show $75.00 third no show	Discharge from practice

I have read the above and completely understand the language and meaning of the attestation no show policy given to me, and I have had a chance to ask questions of my doctor or staff about this policy and am willing to comply with Lehigh Valley Dermatology's no show policy. I understand the terms above and realize that if I violate the Lehigh Valley Dermatology's no show policy, I will be discharged from the practice and pay for no show visits, and that any and all means necessary to collect the fees for the no show visits will be pursued.

I have read the above no show attestation policy and agree to the terms of the policy.

______________________________ ______________

Patient Name - please print Date of birth

______________________________ ______________

Patient signature Date

______________________________ ______________

Witness Date

MEDICARE

I request that payment authorized Medicare benefits be made on my behalf to Lehigh Valley Dermatology Associates, Ltd. for any services furnished me by that physician group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person) ______________________________
A copy of this signature is valid as the original.

MEDIGAP

Name of Medigap Insurer: ______________________ Medigap Policy#: ______________

Medigap Insurer's Mailing Address: ______________________________

____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Lehigh Valley Dermatology Associated, Ltd. for any services furnished me by the physician group. I authorize any holder of medical information about me to release to ______________________ and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person) ______________________________
A copy of this signature is valid as the original.

INSURANCE AUTHORIZATION

I hereby authorize release of any information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Lehigh Valley Dermatology Associates, Ltd. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signed (insured or authorized person) ______________________________
A copy of this signature is valid as the original.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ Date of Birth: ______________

Address: ____

Practice Name: Lehigh Valley Dermatology Associates, Ltd.

I have been given a copy of Lehigh Valley Dermatology's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Lehigh Valley Dermatology has the right to change this notice at any time. I may obtain a current copy by contacting the Regulatory Compliance Manager's email (audrey@lehighvalleyderm.com), or by visiting the Lehigh Valley Dermatology's web site at **lehighvalleyderm.com.**

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practice:*

____ ______________________
Signature of Patient or Personal Representative Date

____
Print Name

____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement,* or the *Acknowledgement* is not signed for any other reason, state the reason:

____

____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:

____

____

Completed by:

____ ______________________
Signature of Practice Representative Date

HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends: It is the office policy of Lehigh Valley Dermatology Associates not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations or (v) other, as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing or call our staff.

Spouse: ______________________________ ______ No

Parent: ______________________________ ______ No

Other: ______________________________ ______ No

______________________________ ______ No

______________________________ ______ No

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: ______________________________

____

____

PRINTED NAME: ______________________________

Patient/Parent/Guardian Signature: ______________________________

Date: ______________________________

- -

FOR OFFICE USE

Changes to above authorized by patient over the phone:

Change	Date	Staff Initials

LVDA072920hipaapatientcommunicationform

Lehigh Valley Dermatology Associates, Ltd.
940 N New St
Bethlehem, PA 18018
610-866-2010

Patient Consent for Medical Photography

Patient Name: X_________________________ DOB: X___________ Date: X______________

- Check here if you are a minor or unable to provide consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information will be used in my medical record, for purposes diagnosis, tracking my progress, progression of a condition and or treatment, keeping a visual history, medical teaching and reporting to referring physician. Refusal to consent to photographs will in no way affect the medical care I will receive. However, please keep in mind refusal may limit our ability to track your progress or progression of a condition if we do not have visual documentation. I understand that I am able to withdraw my consent at any time.

- To withdraw my consent in the future I may contact:
  Office Manager - Kristin Hardiman – (610) 866-2010
- Questions pertaining to patient rights will be filtered through the Office Manager to the Regulatory Compliance Manager – Audrey Kovacs

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By signing this form below I confirm that this consent has been explained to me in terms in which I understand.

1) I consent for my photographs to be used in medical record as part of my visual patient history for purposes of diagnosis, tracking my progress or progression of a condition and/or treatment and to provide a copy to my medical image(s) to include at the referring physician's office.

   _________________________ (Print) _________________________ (Signature)

2) I agree for my medical image(s) to be used for medical teaching purposes.

   _________________________ (Print) _________________________ (Signature)

3) I DO NOT consent to any medical images to be taken. I understand that refusal to consent to medical images taken as part of my medical record may limit my provider's ability to effectively track my progress or progression of a medical condition.

   _________________________ (Print) _________________________ (Signature)

Office Employee Witness ______________

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BETHLEHEM, PA 18018
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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: ____

Date of Birth: ____________ Medical Record: __________

Patient Address: ______________________________ City, State: __________ Zip: ______

Date Consent Discussed: ___________ Physician Name: _____________ Location: _________

INTRODUCTION Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.

Obtaining expertise of a distant specialist.

Please initial after reading this page: ________

INFORMED CONSENT FOR TELEMEDICINE PAGE 2

POSSIBLE RISKS As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, 2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment, 3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee, 4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. _____________ has explained the alternatives to my satisfaction, 5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. 6. I understand that it is my duty to inform ____________________ of electronic interactions regarding my care that I may have with other healthcare providers. 7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 8. I attest that I am located in the state of Pennsylvania and will be present in the state of Pennsylvania during all telehealth encounters with ___________________.

PATIENT CONSENT TO THE USE OF TELEMEDICINE I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize (__________________) to use telemedicine in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE: ________________________________ **DATE:**___________
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

WITNESS DATE:

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

____ **DATE:** __________
PHYSICIAN'S SIGNATURE

I have been offered a copy of this consent form. _______