Vista HEALTH

NAME: ..... **AGE:** ..... **D.O.B.** ...../...../..... **DATE:** ...../...../.....

HEIGHT: ..... **WEIGHT:** ..... **REFERRED BY:** .....

REASON FOR THIS VISIT .....

.....

MEDICAL HISTORY *(Please check appropriate box(es)):*

ILLNESS	WHEN DIAGNOSED
❒ Heart Attack	.....
❒ Stent / Balloon Procedure	.....
❒ Heart Surgery	.....
❒ Rheumatic Fever ❒ Murmur	.....
❒ Irregular Heartbeats	.....
❒ High Cholesterol	.....
❒ Circulation Problem	.....
❒ High Blood Pressure	.....
❒ Diabetes	.....
❒ Stroke	.....
❒ Lung Disease	.....
❒ Kidney / ❒ Liver Problems	.....
❒ Ulcer ❒ Acid Reflux	.....
❒ Thyroid Disease	.....
❒ Arthritis ❒ Other	.....

SURGICAL HISTORY

(List procedure and date.)

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HABITS

Do you smoke? .....

Quantity? .....

Do you drink alcohol? .....

Quantity? .....

ALLERGIES

.....

.....

FAMILY HISTORY *(Please state relation and age of family member.)*

❒ Heart Attack.....

❒ Heart Bypass or Stent.....

❒ Vascular Problems or Aneurysm.....

❒ High Blood Pressure..... ❒ Stroke.....

PRESENT MEDICATIONS *(Please state medication and dose.)*

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PLEASE DO NOT WRITE BELOW THIS LINE. (For Office Use Only)

ROS: ❒ Chest Pain

❒ Dyspnea - exertional / resting / orthopnea

❒ Edema ❒ Claudication ❒ Arrhythmia ❒ Am. Fugax

❒ Dizziness ❒ Syncope ❒ Bleeding ❒ Other

P/E: Ht..... Wt..... HR..... BP..... R..... ❒ JVD ❒ Edema

Carotid Bruit: ❒ Rt ❒ Lt Murmur: ❒ Systolic ❒ Diastolic

❒ Gallops ❒ Pulm. Ausc. ❒ Peripheral Pulses

RX: Counsel - ❒ Diet ❒ Habits ❒ Wt ❒ Previous Records

❒ TM ❒ Ex. Myoview ❒ Adenocard ❒ Dobutamine ❒ Echo ❒ Carotid u/s

❒ Holter ❒ Event Recorder ❒ ABI ❒ Labs

MEDS/Δ: .....

.....

PATIENT PROFILE

DOCTOR: .....

PATIENT INFORMATION

NAME : _____

MAILING ADDRESS: _____

_____

CITY, STATE, ZIP: _____

_____

PHONE: _____ ( ) HOME ( ) WORK

PHONE: _____ ( ) HOME ( ) WORK

PATIENT ID#: _____ SEX: ( ) MALE ( ) FEMALE

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

MARITAL STATUS:

( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED

REFERRING PHYSICIAN: _____

PRIMARY PHYSICIAN: _____

LANGUAGE: _____

RACE: _____

ETHNICITY: _____

PATIENT EMPLOYMENT

( ) EMPLOYED ( ) RETIRED ( ) DISABLED

PHONE: _____

EMPLOYER: _____

RESPONSIBLE PARTY

( ) SAME AS PATIENT

NAME: _____

ADDRESS: _____

_____

CITY, STATE, ZIP: _____

EMERGENCY CONTACTS

_____

_____

_____

RELATIONSHIP TO PATIENT: _____

INSURED ID: _____

POLICY GROUP: _____

DATE OF BIRTH: _____

PRIMARY INSURANCE

INSURED PARTY: _____

INSURED PHONE: _____

COMPANY: _____

RELATIONSHIP TO PATIENT: _____

INSURED ID: _____

POLICY GROUP: _____

DATE OF BIRTH: _____

SECONDARY INSURANCE

INSURED PARTY: _____

INSURED PHONE: _____

COMPANY: _____

RELATIONSHIP TO PATIENT: _____

INSURED ID: _____

POLICY GROUP: _____

DATE OF BIRTH: _____

RELEASE OF BENEFITS AND INFORMATION

I CONSENT FOR MEDICAL TREATMENT AND I HAVE VERIFIED THE INSURANCE LISTED ON THIS SLIP AND AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE DOCTOR. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I AUTHORIZE THE DOCTOR OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. I HAVE READ AND UNDERSTAND THE OFFICE INSURANCE/PAYMENT POLICY STATED ABOVE.

SIGNED: _____ DATE: _____

VISTA HEALTH

CANCELLATION POLICY

As of February 1st, 2024

Please be aware of our 24-hour cancellation policy.

Because it is difficult to fill a cancelled appointment without sufficient notice, appointments cancelled without 24 hours' notice and missed appointments will be charged a fee of $75.

If you need to cancel your appointment, please call, or text us at least 24 hours in advance. We can be reached at 928-768-2558 or via text at 928-577-9114 or 928-577-9117

Thank you!

Vista Health

Management

I, _____, have read and acknowledge the above written policy.

_____ _____

Patient Signature Date

VISTA HEALTH

POLICY OF ACQURING MEDICAL RECORDS

1. Patient must sign an in person written release request form of medical records. Release can be signed by the patient themselves and or their Power of Attorney (POA). POA must show ID and documents that the person obtaining your medical records has the authority to acquire your medical records on your behalf. If acquiring your medical records on your own or with an POA, **there will be a charge of $ 0.60 per page.**

   Once the request is signed and given to the receptionist, the medical records will be reviewed and printed. **We require the patient to give the office 5-7 business days for the request to be completed depending on the extent of dates and volume of medical records requested.**

   The records can be either picked up in person by the patient, POA and or the clinic can send the medical records via MAIL if patient requests it in the written request or verbal consent that patient wants their medical records mailed to their home.

2. Primary care providers or any other doctors requesting your medical records can send a fax requesting your medical records with your signed statement for release of the records. **If a doctor's office sends the request via fax, then this will be submitted to the requesting doctor's office without any fee charged.**

_____ _____

PATIENT'S SIGNATURE **DATE**

VISTA HEALTH

Patient Financial Responsibility Policy

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein.

Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit the same to Vista Health until your patient account is paid in full.

If you make a payment that results in a surplus on your account, you authorize Vista Health to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, in which case that will be ultimately the patient's responsibility.

We must emphasize that, as health-care providers our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to you, all charges are your responsibility from the date of services are rendered. We realize temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us immediately and promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSBILITY POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE STATUS, I (the patient/parent/guardian) AM RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES.

I UNDERSTAND THERE WILL BE AN ADDITIONAL 30% CHARGE ADDED TO ANY BALANCE ON MY ACCOUNT THAT IS REFERRED TO A COLLECTION AGENCY FOR SERVICES RENDERED FROM THIS DATE FORWARD.

I authorize my insurance benefits to be paid directly to my physician and understand that I am financially responsible for the uncovered services.

Date: ____/____/_____ Patient/parent/guardian:_____

ACKNOWLEDGEMENT

(OF RECEIPT OF NOTICE O PRIVACY PRACTICES)

I hereby acknowledge that a copy of Vista Health's Notice of Practices was provided to me. I further acknowledge and understand that if I have questions about Vista Health's privacy practices or my rights with regard to any of my personal health information. I may contact Vista Health's contact person for further information as set forth in the Notice.

Name of Patient (or Patient's representative, if one)	**Patient Social Security #**
Signature of Patient (or Patient's Representative)	**Date**

VISTA HEALTH

DISCLAIMER AND CONSENT

Patient agrees that in case of any disagreement regarding care at Vista Health, patient will discuss with the provider and or office manager in person to clarify, rectify and resolve all issues in house. Patient has read all the policies and agree that they are not going to get any provider of Vista Health and or involve the group practice Vista Health in any kind of civil or criminal litigation. All matters must be resolved amicably. This is a voluntary consent by signing this consent below.

Patient verbalizes and provides us in writing complete consent that there will be no litigation in any court of law or reporting authority. This is a voluntary act. This is done to avoid any unnecessary stress and conflict with any and all providers of Vista Health, including Vista Health itself and all staffers.

Patient has been provided complete opportunity and they have every right to leave and find another provider should they not agree with the above disclaimer. If a patient disagrees with the above, Vista Health will have no bearing, and will be happily able to provide Medical Records at the appropriate cost and time to transfer care to any provider in the area.

Patient's Signature	Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

PURPOSE OF THIS NOTICE

Our office respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This notice describes our privacy practices with respect to your health information. Our privacy practices apply to current and former patients.

TYPES OF PERSONAL AND HEALTH INFORMATION WE COLLECT

We collect a variety of personal and health information when delivering health care. You provide some of this information when you initially come into the office (such as address, Social Security Number, and health history). We also receive additional personal and health information (such as eligibility) through our transactions with employers, insurance companies, and other health care providers. We limit the collection of personal information to what is necessary to administer our business, provide quality service, and meet regulatory requirements.

HOW WE PROTECT PERSONAL AND HEALTH INFORMATION

We treat personal and health information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide services to patients (for example, our billing clerks and medical assistants). These people are trained in the importance of safeguarding this information and must comply with our procedures and applicable law. We meet physical, electronic, and procedural security standards to protect personal and health information and maintain internal procedures to promote the integrity and accuracy of that information.