Welcome to Vista Physician Group

We thank you for choosing Vista Physician Group! Please ensure the enclosed paperwork is completed in its entirety.

□ Patient Notification Preference

If for any reason, including test results (abnormal or normal) how would you prefer to be contacted by our office?

□ **Home Phone** □ **Cellphone** _____ □Do Not Leave Message

□Leave Message

□ With Details (no test results are left on voice mail) □ Brief Message to Call Office Back

□ Leave Message With Family Member_____

□**Mail Notification** Mailing Address_____

□ **eMail**_____ for patient portal registration.

□ No-show & Cancellation Policy

In an effort to maximize clinical access and improve scheduling efficiencies, Vista Physician Group has implemented a new No show & Cancellation policy. Patients who fail to present for a scheduled appointment without contacting the Practice to cancel the appointment within 24 hours will be considered a "no-show". **Patients will be considered for discharge from Vista Physician Group after 3 no-shows within a rolling 6 months.**

□ Consent for Medical Treatment/Procedure

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Vista Physician Group and its associated physicians, clinicians and other personnel.

I/We give consent to be given medication and/or procedural care while in the office if clinically advised.

I/We are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantees have been made as to the result of treatments or examinations.

I/We consent to lab testing, nut not limited to Syphilis, AIDS, Hepatitis and testing for drugs if deemed advisable by my physician.

□ Clinical Photographs Consent

I understand that clinical photographs may be taken and used for medical purposes only as part of my medical record.

□ E-Prescribing Consent

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have also been informed, understand and I give consent that my providers will be able to see information about my medications I am already taking, including those prescribed by other providers and I have been provided the Electronic Prescribing Notice.

I hereby acknowledge that I have read and agree to the above policies and notices as a patient with Vista Physician Group.

Patient or Legal Representative's signature	Relationship to Patient	Interpreter, if Utilized	Date	Time
Witness Signature			Date	Time
If Telephone Consent, Second Witness Signature			Date	Time

Waukegan Clinic Corporation Patient Registration

Patient Last Name:_____ First Name:_____ Date of Birth:_____SSN:_____□ M □ F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: □ Single □ Married □ Domestic Partner □ Divorced □ Separated □ Widowed

Employer:_____ Employer Address:_____ Occupation:_____

Guardian and/or Spouse:

Guardian Last Name:_____ First Name: _____ Date of Birth: _____

Address: _____City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Relationship to Patient:_____ SSN:_____

Employer:_____ Work Phone: _____ Employer Address: _____

Spouse Last Name:_____ First Name: _____ Date of Birth: _____

Address: _____City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Relationship to Patient:_____ SSN:_____

Billing Information:

Send Bills To: □ Patient □ Guardian □ Spouse

Mailing Address for Bills: □ Same as above □ Other_____

Emergency Contact: *Note two contacts with phone number required.*

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Insurance Information:

Primary Insurance:_____ PolicyID:_____ Group Number: _____ Effective Date:_____

Claims Address:_____ Insurance Phone Number:_____

Policy Holder Name:_____ SSN:_____ Date of Birth:_____

Employer:_____ Policy Holder Relationship to Patient:_____

Secondary Insurance:_____ PolicyID:_____ Group Number: _____ Effective Date:_____

Claims Address:_____ Insurance Phone Number:_____

Policy Holder Name:_____ SSN:_____ Date of Birth:_____

Employer:_____ Policy Holder Relationship to Patient:_____

I authorize the release of any medical information necessary to coordinate care with other physicians and to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by my insurance company to pay directly to Waukegan Clinic Corporation.

Patient Signature:_____ Guardian/Spouse Signature:_____ Date:_____

Permission to Verbally Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____ Medical Record Number: _____

Patient Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____ Work Phone Number: _____

I give my permission to VERBALLY discuss the following medical information about me (*check all that apply*):

- ☐ Medical Information (symptoms, diagnosis, medications and treatment plans)
- ☐ Lab and Test Results
- ☐ Billing
- ☐ Appointments
- ☐ Other (describe): _____

The physician practice has my permission to discuss the above information with the following:

1. Name/Relationship to Patient: _____

   Street Address, City, State, Zipcode: _____

   Phone Numbers (Home, Cell, Work): _____

2. Name/Relationship to Patient: _____

   Street Address, City, State, Zipcode: _____

   Phone Numbers (Home, Cell, Work): _____

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. I understand that I must notify the physician practice in writing if I wish to revoke my permission.

Patient or Authorized Person(s)' Representative Signature: _____ Date: _____ Time: _____

Relationship to Patient / Authority to Act on Patient's Behalf: _____ Date: _____ Time: _____

Interpreter, if utilized: _____ Date: _____ Time: _____

Witness Signature: _____ Expiration Date or Event : _____

Date: _____ Time: _____

If Authorized Representative, please sign and attach copies of supporting legal documentation.

Reason if patient unable to sign:

_____

Permission to Verbally Discuss Protected Health Information

The Physician practice knows that privacy regulations have an impact on our customer services to you, especially when it comes to discussing information about you with family, friends and others you designate who is involved in your care.

How can I give others permission to get verbal information about me?
Anytime your designated person calls or make a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions.
- If a friend is helping an elderly patient with health issues.
- If a college student wants information shared with a parent

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our Physician Practice(s).

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your Physician Practices(s).

What happens if I don't complete this form?
We will continue to protect your private health information as required by law.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

I hereby acknowledge that I have read and agree to the above policies and notices as a patient with Vista Physician Group.

Patient or Legal Representative's signature		Date	Time
Relationship to patient	Interpreter, if Utilized	Date	Time
Witness Signature		Date	Time
If Telephone Consent, Second Witness Signature		Date	Time