

Vista Family Medicine
10961 S. Kedzie Ave., Chicago, IL 60655
Phone (773) 239-9100 Fax (773) 239-9102
Jim Valek, M.D. Monica Ryan, APN/CNP Tiffany Grant, APN/CNP

**THIS DOCUMENT ACKNOWLEDGES TREATMENT, FINANCIAL RESPONSIBILITY
CONSENT FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

**VISTA FAMILY MEDICINE INC. WILL OBSERVE THE FOLLOWING RULES
AND PROCEDURES**

- YOU HAVE A RIGHT TO A COPY OF THE NOTICE OF PRIVACY PRACTICES
- YOUR MEDICAL INFORMATION IS KEPT SECURE AND PRIVATE
- STAFF MEMBERS MAY HAVE ACCESS TO YOUR CHART
- YOU HAVE A RIGHT TO YOUR RECORDS (THERE IS A FEE FOR COPYING)
- A DIAGNOSIS IS ALWAYS NECESSARY WHEN DISCUSSING OR SHARING INFORMATION ABOUT YOUR HEALTH CARE WITH LABS, HOSPITAL, OTHER PHYSICIANS AND OTHER INSURANCE COMPANIES
- WORKMEN’S COMPENSATION CASES WILL STILL BE TREATED UNDER THE GOVERNMENT PROVISION ACT
- YOU HAVE THE RIGHT TO COMPLAIN TO THE PRIVACY OFFICIAL IF YOU DO NOT FEEL THAT YOUR RIGHTS ARE BEING PROTECTED
- YOU HAVE THE RIGHT TO REVOKE YOUR WRITTEN CONSENT AT ANY TIME, EXCEPT WHEN THE USE OR DISCLOSURE HAS ALREADY OCCURRED

***** SAFEGUARDS*****

- IT IS OUR POLICY TO SHRED EVERY DOCUMENT WHEN DESTRUCTION IS NECESSARY
- WE WILL USE CONFIDENTIAL SIGN IN SHEETS
- WE WILL NEVER USE YOUR INFORMATION FOR FUND-RAISING
- YOU MAY BE ASKED TO VERIFY TO WHOM WE ARE SPEAKING WITH

***** COMMUNICATION METHODS*****

WE MAY CONTACT YOU ABOUT THE FOLLOW-UP EXAMS, PAP SMEARS, MAMMOGRAMS, BLOOD WORK, DIABETIC EXAMS, ETC... BY TELEPHONE OR MAIL AS USUAL. IF WE LEAVE A MESSAGE AT YOUR HOME IT WILL BE BRIEF, EXAMPLE: CALL YOUR DOCTOR’S OFFICE AT 773-239-9100. IF YOU DO NOT WANT US TO USE THESE METHODS, PLEASE STATE SO BELOW

PLEASE CHECK ALL THAT APPLY:

- You may contact me by mail
- You may contact me by phone-CALLER ID MAY APPEAR and you may leave a detailed message
- You may release information about me to my family that I have listed below (please indicate name & phone number)

Name _____ Phone _____

I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES AND RULES
VISTA FAMILY MEDICINE HAS THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT
ARE DESCRIBED IN THIS NOTICE.

X _____
Signature of patient Date Print name D.O.B.

X _____
Signature of parent/legal guardian Relationship to patient