Welcome to VISTA Behavioral Health Associates. VISTA Behavioral Health Associates is a large multispecialty behavioral health practice comprised of a diverse staff of psychiatrists, psychologists, social workers and counselors. VISTA has office locations in Oakland, Moon Township, Pleasant Hills, South Hills and Wexford. In order to better serve you, the following information addresses our office policies and procedures. Please review this information carefully and keep it for your records. Our business office hours are Monday - Friday 8:30 a.m. - 5:00 p.m. Clinical appointments are scheduled according to availability for each provider.

- Copayments/Co-insurance/Deductibles/Direct Payments - All payments must be paid at the time of your scheduled appointment. We will charge a $5.00 billing fee for each copayment not paid at the time of service. Co-insurance and/or deductibles are determined by your insurance plan. Therefore, we are unable to waive or bill these charges. VISTA reserves the right to discontinue services to you if payment is not made at the time of the appointment or if your account is not paid in full.
- Appointments - We respectfully ask you to be prompt and to keep your scheduled appointment. We require at least 24 "business" hours notice of cancellation. Otherwise, in most cases you will be charged our full fee. This fee is due prior to the next scheduled appointment or upon receipt of an invoice, whichever is sooner.
- Medications - If you are seeing a psychiatrist and medications are prescribed, it is very important that you keep your scheduled appointments. Always check in advance to determine if you need more medication before your next scheduled appointment. We require one weeks' notice for all prescription refills and will prescribe only enough medication until your next scheduled appointment. Federal law prohibits us from calling in certain medications, for example, Ritalin. In these instances, the prescription must be picked up at the VISTA office. We are sorry that we are unable to honor emergency refill requests for medications that were previously prescribed.
- Emergencies - If you are experiencing an emergency, please contact the office where you are seen. If the office is closed, a voice message will instruct you where to call. VISTA has a provider on call for emergencies 24 hours per day, 7 days a week.
- Completion of forms - If you need to have forms completed by the therapist or psychiatrist, we require an original copy of a signed release/consent form. We also require at least 5 working days for the completion of the form. There is a fee for the time needed to complete each form and the fee must be paid before the form will be sent to the appropriate party. We will not fax a completed form.
- Copies of medical records - If another agency requests copies of your medical records, we require an original copy of a signed release/consent form. We also require at least 5 working days for copies to be made. We will not fax copies of medical records. There is a per page charge for all copies, other than those provided to another professional for the purpose of continuity of care.
- Confidentiality - In order to protect your right to privacy, we are unable to accept telephone calls or requests for information from any person other than the patient or the guardian of a minor patient without a signed release form. Please inform family members and friends about this policy and request that they not contact our office on your behalf. In the event that we should retain a collection agency to collect accounts with past due balances, we will send the collection agency the following information: Name, Address, Date of Birth, Social Security Number, Telephone Number(s), Date(s) of Service and Amount Past Due.

VISTA
Behavioral Health
Associates

Oakland
230 N. Craig Street
Suite B
Pittsburgh, PA 15213
(412) 621-3777
Fax (412) 622-7595

South Hills
1370 Washington Pike
Suite 303
Bridgeville, PA 15017
(412) 206-0123
Fax (412) 206-0128

Wexford
11676 Perry Highway
Suite 2100
Wexford, PA 15090
(724) 934-7722
Fax (724) 934-5955

Moon
1000 Commerce Drive
Suite 1008
Moon Twp., PA 15108
(412) 299-8404
Fax (412) 299-7818

Pleasant Hills
275 Curry Hollow Road
Suite 205
Pittsburgh, PA 15236
(412) 655-6480
Fax (412) 655-6511

PATIENT INFORMATION

Social Security #: ____________________

Last Name: ____________________ First Name: ____________ Initial ____

Street Address: ____________________

City: ____________________ State: ________ Zip Code: ____________

Home Telephone Number: ______________ Work Telephone Number: ______________

Sex: ____ Date of Birth: ________ Marital Status: ________ Maiden Name: ____________

Primary Care Physician: ______________ Physician Telephone Number: ____________

PRIMARY INSURANCE

Name of Insurance Company: ______________ Telephone Number: ______________

Address: ____________________

(City) (State) (Zip)

Identification or Policy Number: ______________ Group or Plan Number: ____________

Subscriber's Last Name: ______________ First Name: ____________ Initial: ____

Address: ____________________

Subscriber's Social Security #: ______________ Relationship to Patient: ____________

Subscriber's Date of Birth: ______________ Effective Date: ____________

Employer's Name: ______________ Telephone Number: ______________

Address: ____________________

(City) (State) (Zip)

SECONDARY INSURANCE

Name of Insurance Company: ______________ Telephone Number: ______________

Address: ____________________

Identification or Policy Number: ______________ Group or Plan Number: ____________

Subscriber's Last Name: ______________ First Name: ____________ Initial: ____

Subscriber's Social Security #: ______________ Relationship to Patient: ____________

Subscriber's Date of Birth: ______________ Effective Date: ____________

Employer's Name: ______________ Telephone Number: ______________

Address: ____________________

(City) (State) (Zip)

EMERGENCY CONTACT

Name: ____________________ Relationship: ____________

Address: ____________________

(City) (State) (Zip)

Home Telephone Number: ______________ Work Telephone Number: ______________

Signature required on reverse side

STATEMENT TO PERMIT PAYMENT OF BENEFITS TO VISTA BEHAVIORAL HEALTH ASSOCIATES

I request that payment of authorized benefits be made on my behalf to VISTA Behavioral Health Associates for any service furnished to me by that provider. I understand that I am financially responsible for the payment of any deductible amount, co-insurance, copay and any other balance not paid for by my insurance plan. I authorize any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

Authorization must be signed by the patient or by an authorized person in the case of a minor or when the patient is physically or mentally challenged.

________________________________ ____________________
Signature Date

________________________________ ____________________
Print Full Name Relationship to Patient

101408

FINANCIAL POLICY

Thank you for choosing VISTA Behavioral Health Associates as your behavioral health care provider. We are committed to providing you the highest quality care available at competitive prices. To continue this service excellence, it is very important that you follow our Financial Policy, which includes prompt payment of your bill. The following is a summary of this Policy, which we require all patients to read and sign prior to their treatment.

PATIENT INFORMATION FORM - Please complete the Patient Information Form, which includes demographic, emergency, and insurance information. This will ensure correct billing to your insurance carrier. It will also allow us to contact you in the unlikely event that your appointment needs to be canceled. It is your responsibility to inform us of any changes regarding this information. In the event your insurance changes and you do not notify us of this change in time for us to obtain authorizations or file claims within your insurance company's timely filing deadlines, any unpaid fees will become the subscriber's responsibility.

INSURANCE PLANS ACCEPTED - We accept most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to determine if your policy covers our providers and services. In many cases, insurance companies require preauthorization prior to seeking treatment.

BENEFITS INTERPRETATION - We will do our best to help you interpret your health care benefits, but it is ultimately your responsibility to understand which services are covered and which are not under your plan. If you have any questions, please ask your provider to help you with this process.

BILLING YOUR INSURANCE - If it is determined that your insurance is one that we accept, we will gladly bill this company for you. If it is not, or if you do not have insurance, you will be expected to pay for your services in full at the time of your visit. We accept cash, personal checks, or credit card payments.

COPAYMENTS/CO-INSURANCE - Must be paid at the time of your scheduled appointment. We will charge a $5 billing fee for each copayment not paid at the time of service.

BALANCES AFTER YOUR INSURANCE HAS PAID - If there is a balance after your insurance(s) has paid, you are responsible for payment of this balance. If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt. VISTA reserves the right to discontinue services to you if your account is more than 30 days past due or to refuse services if payments owed at the time of service are not paid. Accounts more than 90 days past due or with undeliverable addresses may be forwarded to a collections agency for recovery.

ACCOUNT RESPONSIBILITY - It is our policy to bill the subscriber of the insurance for any balances left on the account. This "account" includes services rendered to a spouse and/or dependents. If any responsible party fails to make timely payments on their portion of the account we reserve the right to refuse treatment. If you do not have insurance, you are personally responsible for your own debt and payment is expected at the time of service. In the case of minor patients with no insurance, the adult accompanying the patient is responsible for payments due at the time of service.

APPOINTMENT POLICY - If you need to change your appointment, we **require at least 24 "business" hours notice to avoid a charge.** The charge for a missed appointment or late cancellation is our FULL fee, due prior to the next scheduled appointment or upon receipt for an invoice, whichever is sooner.

QUESTIONS ON YOUR BILL - Please direct any questions you might have to our billing department at (412) 206-0135. Thank you for taking the time to read our Financial Policy, and thank you again for choosing VISTA Behavioral Health Associates. If you have any questions, please do not hesitate to ask.

FINANCIAL POLICY SIGNATURE PAGE

I have read Vista Behavioral Health Associates' Financial Policy and agree to its terms. By signing below, I consent to the release of financial information to the subscriber of my insurance policy for the purpose of obtaining payment for VISTA services not covered by my insurance.

______________________________ ______________
Signature of Patient or Responsible Party Date

____
Print Full Name

11/06

FAQS ABOUT VISTA'S LATE CANCEL/NO SHOW POLICY

What is your policy on missed appointments?
If you do not appear for your scheduled appointment, or if you cancel your appointment with less than twenty-four business hours notice, we charge a late cancel/no show fee equal to Vista's full fee for the service.

Why do you charge fees for missed appointments?
When you make an appointment, you are reserving a particular block of time with your provider. This time is reserved for you and no one else. When you fail to appear for a scheduled appointment, or you do not give us sufficient notice to schedule someone else in your place, valuable treatment time goes to waste. And since your provider is a professional who is reimbursed on a fee-for-service basis, the wasted time also results in a loss of income for your provider.

Why should I have to pay for a service that I didn't receive?
You are paying for a time that you asked us to reserve for you. We would much prefer that you come to your appointment and receive the service. However, when you don't appear as scheduled, it is not fair to your treating provider, or to other patients who might have used the time.

If I didn't get a reminder call, why should I have to pay a fee?
For some services, especially psychiatry, where appointments are often scheduled months in advance, we try to call and remind patients of their appointment times. We provide appointment reminder slips and reminder calls as a courtesy. However, there are times when we are not able to make reminder calls. Ultimately, it is your responsibility to remember the date and time of your appointment, even if you don't receive a reminder call.

Are these fees covered by my insurance?
No. They are the responsibility of the patient, or whoever signs the financial responsibility forms.

When are the fees due?
The fees are due prior to the next scheduled appt or upon receipt of an invoice, whichever is sooner.

Can I dispute a late cancel/no show fee?
Certainly. If you dispute the charge, you should contact us within 30 days of receiving an invoice. It is our policy to forward charges not paid within 90 days to our recovery agency. If this happens, it may adversely affect your credit rating.

What if I have a true emergency? Are you still going to charge a late/cancel no-show fee?
We understand that true emergencies do sometimes occur. Please speak with your provider if you believe that a true emergency prevents you from giving adequate notice or coming to your appointment at the scheduled time.

If I have other questions about this policy, what do I do?
Please speak with your provider or with the secretary in the office where you are seen. They will be able to answer your questions, or refer you to someone who can.

Consent to Treatment

Welcome to Vista Behavioral Health Associates. As a new client, you should have received this consent handout as well as our Financial Policy, "Patient Information Sheet, Authorization to Disclose Information to Primary Care and Insurer, Members' Rights and Responsibilities Statement and Notice of Privacy Practices. Please read them over carefully and if you have any questions or concerns about what you have read, please raise them with your therapist or psychiatrist.

You can expect to be treated with respect and courtesy by all Vista staff. We ask that you be an active participant in all decisions made concerning your care. It is important that all treatment goals and recommendations be mutually agreed upon. You do not have to allow the use of any particular technique or participate in any treatment assignment that you feel is inappropriate for you. During the course of treatment, we encourage you to talk with your therapist or psychiatrist about how your therapy is progressing, and to voice any concerns directly with your provider. If necessary, you can also ask to speak with a Vista manager about your concerns.

Confidentialty and Communication with Others

Your rights as a client at Vista include respect for your privacy and confidentiality of your treatment records. We will not acknowledge that you are a client with us or release any information about your treatment without written consent from you. However, there are very rare exceptions when we may be compelled by law to release information without your consent:

1. If you seriously threaten to harm another person, we must warn that person.
2. If we come in contact with a child and there is evidence to suggest he/she is a victim of abuse or neglect, we must notify the proper authorities.
3. If you seriously threaten to harm yourself or have attempted to do so while in treatment, we will notify others to the extent necessary to secure your safety.
4. If a court orders us to testify about your treatment, we must comply.

At your initial session with us, you will be asked to sign a release of confidential information for your insurance company. Most insurance companies require us to provide your clinical diagnosis and additional information such as treatment plan or treatment summary in order to authorize payment for your sessions. You may refuse to allow us to release this information, however, your insurance company will most likely refuse to cover your services at Vista.

In addition, we will be asking if you will permit us to communicate with your primary care physician. This communication typically includes the following information: type and frequency of sessions, medications we prescribe and diagnosis. You may decline to allow us to communicate with your primary care physician and we will honor your request. However, in some cases this may have a detrimental effect on both your medical and behavioral health treatment.

Psychiatric Advance Directives

Pennsylvania Act 194 mandates your right to a Psychiatric Advance Directive in the event of incapacity.

Do you have a formal Mental Health Care Declaration (for the case of incapacity) or Power of Attorney form declaring a Mental Health Care Agent? **Yes / No** If you answered yes or you have questions about this, please notify your Vista provider.

Finally, we will be happy to hear any suggestions you might have about our policies regarding your treatment at Vista. You can discuss these with your therapist, psychiatrist or Vista manager.

I, ______________________________, have read the consent handout, the Financial Policy, "Patient Information Sheet, Authorization to Disclose Information to Primary Care and Insurer, Members' Rights and Responsibilities and Notice of Privacy Practices. I understand what I have read and I hereby give my consent for treatment.

______________________________ ______________________

Signature of patient or parent/guardian Date

Copy Accepted by Client: YES _______ NO _______

Authorization to Disclose Information to Primary Care Physician and Insurer

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ______________________________ hereby authorize VISTA Behavioral Health Associates
(Print Patient's Name)

Please check all that apply:

Primary Care Physician

_____ To release any applicable information to my Primary Care Physician

_____ To release medication information only to my Primary Care Physician

Primary Care Physician's Name, Address & Phone:

____

____

____

_____ **DO NOT** release information to my Primary Care Physician

Insurer/Managed Care Company

_____ To release treatment plan information to ______________________________
(Insurance/Managed Care Company)
as required for authorization of treatment/payment

____
(Patient's or Patient's Guardian Signature)

____
(Patient's Date of Birth)

____
(Print the name signed above

____
(Date)

Patient's Rights and Responsibilities Statement

Patient Rights

- Patients have the right to receive considerate and courteous care, with respect and dignity for personal privacy.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Patients have the right to expect their provider's team of workers to provide or to help them arrange for all of the mental health care that they need.
- Patients have the right to participate in the mental health care process and to be informed of their diagnosis and treatment.
- Patients have the right to information that they understand and to participate in decisions involving their care.
- Patients have the right to receive enough information to talk openly with their provider about appropriateness and medically necessary treatment options and be able to make a thoughtful decision prior to treatment, regardless of cost or benefit coverage.
- Patients have the right to confidential records, except when disclosure is required by law or permitted in writing by them with adequate notice. They have the right to review their mental health records with their provider.
- Patients have the right to express a complaint and receive an answer to the complaint within a reasonable period of time.
- Patients have the right to expect that emergency procedures will be implemented without any unnecessary delay.
- Patients have the right to make recommendations regarding Vista Behavioral Health Associates Patients' Rights and Responsibilities.

Patient Responsibilities

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to carefully read all of their member literature or contact their insurance carrier and ensure that they understand their benefits and policy requirements.
- Patients have the responsibility to communicate openly with the provider, ask questions, make certain they understand the explanations and instructions they are given and develop a provider-patient relationship based on trust and cooperation.
- Patients have the responsibility to help maintain their mental health and consider the potential consequences if they refuse to comply with treatment plans and recommendations.
- Patients have the responsibility to follow the agreed upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to not take actions that could harm others.
- Patients have the responsibility to keep scheduled appointments or give 24-hour notice of cancellations and adequate notice of delay.
- Patients have the responsibility to help providers maintain accurate and current records by being honest and complete when providing information, including information about all mental health insurance coverage.
- Patients have the responsibility to express their opinions, concerns or complaints in a constructive manner to the appropriate people.
- Patients have the responsibility to pay any applicable copayments, coinsurance or other fees at the time services are rendered.
- Patients have the responsibility to inform their provider about problems with paying fees.
- Patients have the responsibility to report abuse or fraud.

I have read and understand my Rights and Responsibilities.

______________________________ ____________________

Signature Date

Notice of Privacy Practices
Vista Behavioral Health Associates

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Vista may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your general consent. To help clarify these terms, here are some definitions:

PHI refers to information in your health record that could identify you.

Treatment is when Vista provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your Vista provider consults with another health care provider, such as your family physician or another psychologist.

Payment is when Vista obtains reimbursement for your health care. Examples of payment are when Vista discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operations of Vista. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.

Use applies only to activities within Vista's practice group, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

Disclosure applies to activities outside of Vista's practice group, such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Vista may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An **authorization** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your Vista provider is asked for information for purposes outside of treatment, payment and health care operations, he/she will obtain an authorization from you before releasing this information.

He/she will also need to obtain an authorization before releasing your psychotherapy notes. **Psychotherapy notes** are notes your provider made about your conversation during a private, group, joint or family counseling session which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Your Vista provider may or may not have kept private psychotherapy notes separate from your medical record.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your Vista provider has relied on that authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your Vista provider may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If your Vista provider has reasonable cause on the basis of his/her professional judgment to suspect abuse of children with whom he/she comes into contact in a professional capacity, he/she is required by law to report this to the Pennsylvania Department of Public Welfare.

Adult and Domestic Abuse: If your Vista provider has reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), he/she may report such to the local agency which provides protective services.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services Vista has provided you or the records thereof, such information is privileged under state law, and Vista will not release the information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If you express a serious threat or intent to kill or seriously injure an identified or readily identifiable person or group of people, and your Vista provider determines that you are likely to carry out the threat, he/she must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Worker's Compensation: If you file a worker's compensation claim, your Vista provider will be required to file periodic reports with your employer that could include history, diagnosis, treatment and prognosis.

Business Associates: Vista may share health information about you with business associates who are performing services on our behalf. For example,

Vista may contract with a company to service and maintain our computer systems or to transcribe dictations. Our business associates are obligated to safeguard your health information. Vista will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Coroners and Funeral Directors: Vista may disclose health information about you to a coroner if that information is pertinent to the coroner's duties, such as identifying a decedent or determining the cause of death. Vista may also disclose health information to funeral directors to enable them to carry out their duties.

Law Enforcement: Vista may, in response to a warrant or subpoena, disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, Vista may be required to assist law enforcement to locate someone such as a fugitive or material witness, or to provide other information pertinent to an investigation.

Personal Representative: If you are an adult or emancipated minor who has a legally appointed guardian, Vista may disclose health information about you to that person as necessary to make decisions about your health care.

Health Oversight: Vista may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency, such as the state Board of Medicine or a state or county agency to facilitate its auditing, inspection or investigation related to Vista's provision of health care. Please note that psychotherapy notes can only be disclosed to an agency that is overseeing the mental health professional who wrote the psychotherapy notes.

Research: If your treatment is part of a research project for which you have consented, Vista may disclose health information without a written authorization if an Institutional Review Board or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

IV. Patient's Rights

You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Vista is not required to agree to a restriction you request.

You have the right to request that Vista communicate with you by alternative means, such as making records available for pick-up or mailing them to you at an alternate address, such as a P.O. Box. Vista will accommodate reasonable requests for such confidential communications.

You have the right to inspect and/or obtain a copy of PHI in Vista's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Vista may deny your access to PHI under certain circumstances. For example, Vista may deny access to information that would constitute a substantial detriment to your treatment or that would reveal the identity of persons or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality. Vista may also deny access when it is determined that access may endanger the life or physical safety of either you or another person. You will be informed in writing if Vista is unable to satisfy your request, the reason for the denial and your right, if any, to request a review of the decision.

You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Vista may deny your request. On your request, Vista's privacy officer will discuss with you the details of the amendment process.

You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, Vista's privacy officer will discuss with you the details of the accounting process.

You have the right to obtain a paper copy of the notice from Vista's privacy officer upon request.

V. Provider's Duties

Vista is required by law to maintain the privacy of PHI and to provide you with a notice of its legal duties and privacy practices with respect to PHI.

Vista reserves the right to change the privacy policies and practices described in this notice. Unless Vista notifies you of such changes, however, it is required to abide by the terms currently in effect.

If Vista revises its policies and procedures, it will post a copy of the new procedures in each office reception area.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision Vista makes about access to your records or have other concerns about your privacy rights, you may contact Vista's privacy officer:

Privacy Officer
Vista Behavioral Health Associates, Inc.
230 N. Craig St., Suite B
Pittsburgh, PA 15213
412-621-3777

If you believe that your privacy rights have been violated and wish to file a complaint with Vista, you may send your written complaint to Vista's privacy officer at the above address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. Vista will not retaliate against you for exercising your right to file a complaint.

VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice is effective ***April 14, 2003.***

Vista reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. Vista will post any revised notice in each office reception area and on its web site.