VISTA
RADIOLOGY, P.C.
Trusted Specialists. Trusted Results.

Vista Radiology, PC

2001 Laurel Avenue, Ste N304
Knoxville, TN 37916
Office: (865) 595-4100

PATIENT INFORMATION:

Name: _____
Last *First* *Middle Initial*

DOB: _____ Age: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Email: _____

May we leave a message? Y or N May we contact you via email? Y or N

Marital Status: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ May we contact you at work? Y or N

Preferred Pharmacy Address & Phone Number: _____

_____

GUARANTOR INFORMATION: *Complete only if different from above:*

Name: _____
Last *First* *Middle Initial*

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Email: _____

May we leave a message? Y or N May we contact you via email? Y or N

Marital Status: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ May we contact you at work? Y or N

EMERGENCY CONTACT: *In case of emergency, we need a contact that does not live with you:*

Name: _____
Last *First* *Middle Initial*

Home/Cell Phone: _____

Work Phone: _____

May we leave a message? Y or N

Relationship to Patient: _____

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INSURANCE INFORMATION:

Primary Insurance Company: _____

Policy Holder's Name: _____

Last *First* *Middle Initial*

Policy Holder's DOB: _____ SSN: _____

Policy ID Number: _____

Group Number: _____

_____

Secondary Insurance Company: _____

Policy Holder's Name: _____

Last *First* *Middle Initial*

Policy Holder's DOB: _____ SSN: _____

Policy ID Number: _____

Group Number: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____ Date: _____

Relationship to Patient: _____

Vista Radiology, PC will file insurance for all reimbursable services to both your primary and secondary insurance carriers. The patient is responsible for the deductible, co-pay, or any services that are not covered by your insurance carrier. Some services provided by Vista Radiology, PC may be considered investigational or not medically necessary by some insurance carriers. Please be aware that you will be responsible for payment if your insurance carrier considers any service investigational or not medically necessary. Vista Radiology, PC will notify your insurance carrier, prior to any procedures, to the best of our ability. You will be notified if the procedure will not be covered by your insurance carrier prior to the procedure. This is subject to change if the hospital's responsibility to call your insurance carrier.

I have read and understand the above acknowledgement of financial responsibility.

Signed: _____ Date: _____

Relationship to Patient: _____

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Authorization of Records Release

Patient Name: _____

DOB: _____ Phone: _____

I, _____ give my permission to release any medical records and/or radiological images to Vista Radiology, PC.

I, _____ give my permission to release any medical records and/or radiological images to only the following:

_____ (Referring Physician)	_____ (Primary Care Physician)
_____	_____
_____	_____
_____	_____

If you have any questions, you may contact me at the above number.

Patient's Signature: _____

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NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Effective Date: April 21, 2015

PLEASE REVIEW CAREFULLY

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices to review and have therefore been advised of how certain health information about me may be used and disclosed by *Vista Radiology* and how I may obtain access to and control this information. I also acknowledge and understand that I may request a hard copy or copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol, and substance abuse treatment information, mental health information, and certain reproductive health information, and that it will be provided to me if I do request it.

_____ _____

Patient's Signature Date

_____ _____

Legal or Personal Representative of Patient (if applicable) Relationship

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact *Vista Radiology*.