5329 Memorial Drive, Suite A
Stone Mountain Georgia 300083
Phone: 404-296-7695 Fax 404-296- 7695
www.vistasmed.com

PATIENT TREATMENT CONSENT AND HIPAA FORMS

Last Name: ___________________________

First Name: ___________________________ Date of Birth: ___________________

INSURANCE AUTHORIZATION:
I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Vistas Medical Center I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Vistas Medical Center to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims**.**

Signature____ **Date**___________________

Are you the Guarantor? ☐ Yes ☐ No **If not please see receptionist.**

CONSENT FOR TREATMENT:
Having voluntarily presented myself (or my dependent) Vistas Medical Center I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physician.

Signature____ **Date**___________________

RELEASE OF INFORMATION:
I release all of my medical records to Vistas Medical Center including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, and any other statutory protected disease, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physician and/or medical facilities.

Signature____ **Date**___________________

We at Vistas Medical Center value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone numbers below.
Note: Uses and disclosures may be permitted without prior consent in an emergency.

Name	Address	Telephone	Relation