VISTA BEHAVIORAL HEALTH ASSOCIATES

Oakland
230 N. Craig Street
Suite B
Pittsburgh, PA 15213
412-621-3777

South Hills
1370 Washington Pike
Suite 303
Bridgeville, PA 15017
412-206-0123

Wexford
11676 Perry Highway
Suite 2100
Wexford, PA 15090
724-934-7722

Moon Township
1000 Commerce Dr
Suite 1008
Moon Township, PA 15108
412-299-8404

Pleasant Hills
275 Curry Hollow Rd
Suite 205
Pittsburgh, PA 15236
412-655-6480

Welcome to Vista Behavioral Health Associates, a large multispecialty behavioral health practice with a diverse staff of psychiatrists, psychologists, social workers and counselors. Vista has office locations in Oakland, Moon Township, Pleasant Hills, South Hills and Wexford. So that we may better serve you, please review the list of our office policies and procedures below. You may wish to keep a copy of these policies and procedures for your records.

- Appointments – When you schedule a clinical appointment with any of our providers, that time is reserved for you. We respectfully ask you to be prompt and to keep your appointment as scheduled. We require at least 24 business hours notice of cancellation. Otherwise, in most cases you will be charged a late cancel fee. This fee is due prior to the next scheduled appointment or upon receipt of an invoice, whichever is sooner.
- Patient Responsibility Payments - All charges that are patient responsibility and not expected to be paid by your insurance company must be paid at the time of your scheduled appointment. Copayments, coinsurance and/or deductibles are determined by your particular insurance plan. Therefore, we are unable to waive or reduce these charges. Vista reserves the right to discontinue services if payment is not made at the time of the appointment or if your account is not paid in full.
- Medications - If you are seeing a psychiatrist and medications are prescribed, always check in advance to determine if you will need more medication before your next scheduled appointment. We require one week's notice for all prescription refills and will prescribe only enough medication until your next scheduled appointment. Federal law prohibits us from calling in refills of certain medications to your pharmacy. In these instances, the prescription must be picked up at the Vista office. We are unable to guarantee emergency refill requests.
- 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.
- Additional Paperwork/Forms - If you have forms that need to be completed, please discuss this with your treating therapist or psychiatrist. We require at least 5 business days for the completion of a form. We also require an original copy of a signed release/consent before the form can be sent to a third party that you designate. There is a fee for the time required to complete each form and the fee must be paid before the form can be sent to the appropriate party.
- Copies of medical records - If another agency requests copies of your medical records, we require an original copy of a signed release/consent. We also require at least 5 business 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 – We are committed to patient privacy. 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 legal guardian of a patient without a signed release/consent. Please inform family members and friends about this policy and request that they not contact our office on your behalf.

Patient Information

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Birth Date: _____ Sex: _____ Social Security #: _____

Marital Status: _____ Spouse Name: _____

Primary Care Physician: _____ Physician Phone: _____

Referred by: _____

Employer: _____ Employer Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

PRIMARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____
(City) (State) (Zip)

Policyholder's Last Name: _____ First Name: _____ MI: _____

Address: _____ Phone: _____

ID No.: _____ Group No.: _____

Policyholder's Social Security #: _____Sex:____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone Number: _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____
(City) (State) (Zip)

Policyholder's Last Name: _____ First Name: _____ MI: _____

Address: _____ Phone: _____

ID No.: _____ Group No.: _____

Policyholder's Social Security #: _____ Sex: ____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone Number: _____

Financial Policy

Thank you for choosing Vista Behavioral Health Associates as your behavioral health care provider. We are committed to providing you with the highest quality of care at competitive prices. In order for us to continue to do this, it is very important that you review the Financial Policy that all patients are required to read and sign prior to their treatment.

Patient Information Form - Please provide all of the information requested on the Patient Information form**.** Some of this information will help ensure correct billing to your insurance carrier. Some will allow us to contact you in the unlikely event that your appointment needs to be canceled. It is your responsibility to inform us immediately if any of this information changes. It is particularly important that you notify us of any changes in your insurance coverage. If you do not do so, we may not be able to obtain authorizations or file claims within your insurance company's timely filing deadlines. In that event, any unpaid fees will become your responsibility.

Insurance Plans - We participate with most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to make sure that your policy covers our providers and services. In some cases, insurance companies require preauthorization prior to your 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. If you have any questions about this, please ask your provider for help.

Billing Your Insurance - If we are participating providers for your insurance plan, we will bill the insurance company for you. If we are 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. There is a $25 fee for returned checks.

Copayments, Coinsurance & Deductibles – These charges must be paid at the time of your scheduled appointment.

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. Disputes about reimbursements must be resolved between you and your insurance company. Vista reserves the right to discontinue services to you if your account is more than 30 days past due or 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. A $30 collections fee will be added to account balances forwarded to a collections agency.

Account Responsibility - It is our policy to bill the patient or patient's guarantor for any balances left on the account. If the responsible party fails to make timely payments on the account, we reserve the right to discontinue 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, the adult signing this form is responsible for all patient balances, including payments due at the time of service.

Appointment Responsibility - 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 up to our full fee for the service that was scheduled. This charge will be due prior to the next scheduled appointment or upon receipt of an invoice, whichever is sooner.

Questions About Your Bill - If you have questions or require information about your bill, please contact our billing department at (412) 206-0135 between 7 am and 4 pm Monday through Thursday.

Patient Information & Financial Policy Signature Page & Authorization of Payment of Benefits

I have completed Vista Behavioral Health Associates' Patient Information form to the best of my ability with accurate information, including insurance policy details. I have read Vista's Financial Policy and agree to its terms.

I request that payment of authorized benefits be made to Vista Behavioral Health Associates for any services provided to me or to another for whom I am guarantor or legal guardian. I understand that I must promptly notify Vista of changes to my insurance coverage or to the coverage of the person for whom I am guarantor or legal guardian. I acknowledge that I am financially responsible for the payment of deductibles, coinsurance, copayments, and any other charges not paid by my insurance plan or the insurance plan of the person for whom I am responsible, including any non-covered charges, such as missed appointment fees. I authorize the release of medical information to the insurance carrier and its agents for the purpose of determining which of these services are covered.

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

_____ _____

Signature Date

_____ _____

Print Full Name Relationship to Patient

If not patient:

_____ _____

Street Address Date of Birth

_____ _____

City State ZIP Social Security Number

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.

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

Authorization to Disclose Information to Primary Care Physician and Insurer

I understand that my records are protected under the applicable state law governing healthcare 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 to:
(Print Patient's Name)

Please check all that apply:

Primary Care Physician

_____ Release any applicable information to my Primary Care Physician

_____ Release medical information (e.g., diagnoses, medications, compliance**,** symptom ratings) 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

_____ Release treatment plan information to_____
(Insurance/Managed Care Company)
as required for authorization of treatment/payment

Please sign below:

_____ _____
(Patient's or Patient's Guardian Signature) (Patient's Date of Birth)

_____ _____
(Print the name signed above) (Date)

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.

Confidentiality 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 say that you know of a child who is currently being abused, we must notify the proper authorities.
4. If you are 14 or older and you report that you have committed child abuse, even if the victim is no longer in danger, we must notify the proper authorities.
5. 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.
6. 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 _____ *11/15*

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: All Vista Behavioral Health licensed professionals are, by law, mandated reporters of suspected child abuse. If in a licensed professional's judgment there is reason to suspect that a child is or has been abused, he or she is required to report these suspicions to Child Welfare. The licensed professional is required by law to make such a report even if he or she does not see the child in a professional capacity. A licensed professional also is mandated to report suspected child abuse if anyone aged 14 or older reports that he or she committed child abuse, even if the victim is no longer in danger. In addition, a licensed professional is legally mandated to report suspected child abuse if told by another person that he or she knows of any child who is currently being abused.

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 ***January 1, 2015***.

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 website.