Consent to Treat, Payment, and Notice of Privacy Practices

To Treat: I, for myself, or my minor child, hereby consent to and authorize medical treatment to myself or child, which may include the performance of examinations and procedures, use of photography for documentation of exam findings (such as a rash), administration of vaccines, performance of treatments and tests which the physician(s) and provider(s) at North Suburban Family Physicians have advised me of and deemed medically necessary. This permission is granted for in person and remote treatment via secure electronic portal and telehealth platforms. I understand that I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

Release of Information: I hereby authorize North Suburban Family Physicians to release any medical information deemed necessary to process insurance claims (including information relating to the treatment of drug abuse, alcohol abuse, or mental illness).

Authorization of Payment: I further authorize payment of any health insurance benefits directly to North Suburban Family Physicians for services rendered to me or my dependent. This authorization applies to any insurance benefit that was in effect at the time that the services were provided. I understand that I am responsible for any deductible, coinsurance, and all non-covered services for myself or for my child. I am responsible for all returned non-sufficient fund checks with an additional $35 fee per check.

Office and Billing/Insurance Policies: I have been provided a copy of these policies and am aware that I can find them at drtommcgowan.com.

Notice of Privacy Practices: I acknowledge that North Suburban Family Physicians has provided me a copy of its Notice of Privacy Practices. I understand that the Notice describes North Suburban Family Physicians' privacy practices regarding the use and/or disclosure of patient health information. (This Notice is available on our website at drtommcgowan.com and additional copies are available at our front desk).

Permission to Communicate with Other Community Care Providers: I authorize the release of information about my medical condition/treatment to other treating or consulting providers to ensure continuity of care.

Permission to Discuss Medical Information via Non-Direct Avenues or Discuss Information with Specified Family Members:

YES_____ NO_____ I give permission for staff members and providers to leave messages including lab results, test results and information regarding my medical care on a private cellphone or home voicemail.

Preferred Number: _____

Yes_____ NO_____ I give permission for staff members and providers to discuss/share my medical information with:

_____ (name of person and relationship to patient).

By my signature below, I acknowledge that I have read, understand, and agree to the terms of this consent form. I have had the opportunity to ask questions, and that any questions have been satisfactorily answered.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if minor): _____

---This Form Will Expire 1 Year from Today's Date, New Forms Will Need to Be Completed---