Consent for Purposes of Treatment, Privacy, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Family Practice Specialists, S.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for services or to conduct healthcare operations of Family Practice Specialists, S.C. I understand that diagnosis or treatment of me by Richard J. Ferolo, M.D. may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry our treatment, payment or healthcare operations of this practice. Family Practice Specialists, S.C. is not required to agree to the restriction that I may request. However, if Family Practice Specialists, S.C. agrees to a restriction that I request, the restriction is binding on Family Practice Specialists, S.C. and Richard J.Ferolo, M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Richard J. Ferolo, M.D. or Family Practice Specialists, S.C. has taken action in reliance on this consent.

I give Dr. Richard J. Ferolo permission to treat myself/my child, as he deems necessary for my/my child's medical care.

I authorize payment of insurance benefit to be made directly to Dr. Richard J. Ferolo. (Family Practice Specialists, S.C.). I do realize that I am responsible for charges/Co-pays for services rendered to myself/my child.

I authorize the release of medical information in my/my child's insurance provider.

I authorize_____ to make appts/receive medical information on my behalf.

Please check boxes:

❑ Medical information such as test results can be left on my answering machine/voicemail

❑ I have been given information on the Patient Portal

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, health plan, mu employer or health care clearinghouse. This PHI relates to my past, present or future physical or mental condition and identifies me or thee is reasonable basis to believe the information may identify me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Family Practice Specialists, S.C. This notice of Privacy Practices also describes my rights and Family Practice Specialists, S.C. duties with respect to my protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Officer at 847 277-9700, or discuss any questions you may have with your physician.

I have read the above Notice of Privacy Practices prior to signing this document.

_____

Signature of Patient or Patient Representative (If guardian or minor)

_____ _____

Printed Patient Name or Patient representative Date of signature