



Notice of Privacy Practices and Consent to Treat

West Bend Family Medicine's Notice of Privacy Practices gives information about how we may use and release protected health information about you.

I understand that:

- I have the right to receive a copy of the full Notice of Privacy Practices
- I may request a copy at any time
- This notice may be revised, and I am entitled to a copy of any revised Notice of Privacy Practices.

By signing below, I acknowledge the above and that I have received or have been offered a paper copy of the Notice of Privacy Practices. A copy of the Notice of Privacy Practices is also available on our website.

Consent to Treatment

By signing below, I agree to receive medical treatment from West Bend Family Medicine. I understand that:

- This consent will be in effect as long as I am a WBFM Patient
- I may cancel this consent in writing at any time.
- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my clinician

Consent to Disclosure of Protected Health Information

My Protected Health Information is made up of my health history, testing and treatments. By signing this form, I understand and agree that West Bend Family Medicine may use or release my protected health information for purposes of:

- Providing Treatment
- Payment
- Healthcare operations
- Mandatory Reporting Regulations
- As is reasonably necessary to comply with any court order, subpoena, or other legal requirements or regulations as long as a separate authorization is not required under HIPAA regulations; or



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- As is otherwise permitted under HIPAA regulations

Consent to Communication

I authorize West Bend Family Medicine to contact me using the following methods to facilitate treatment, billing, and operations

- **Phone/Voicemail;** WBFM may call the numbers on my medical account and leave messages including voicemail regarding appointment reminders, billing, insurance matters, or information related to my clinical care.
- **Text Messaging;** WBFM may use the phone number on file to send notices and interact with me regarding information related to my clinical care.
- **Mail;** WBFM may send mail or notices to the address I have on file.
- **MyChart;** WBFM uses MyChart platform as a safe and HIPAA compliant platform to discuss my clinical care. MyChart will be used as the primary form of contact as well as be a place to have access to my medical record quickly.
- **Email;** WBFM will NOT use email to conduct patient communication.

I am aware that medicine is not an exact science and acknowledge that no guarantees or promises have been made to me concerning the outcome or results of any of the procedures, treatment, examination, or care authorized by this consent. If you have any questions or concerns, please ask your provider or clinic staff.

I agree that this document was given to me in a language that I understand in writing or as read to me in its entirety.

Printed Name

Relationship to patient

Signature

Date