

NORTHWEST SUBURBAN MEDICAL ASSOCIATES, S.C.
Specializing in Infectious Diseases
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Acknowledgment of Notice of Privacy Practices Form

I, _____, hereby acknowledge the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: _____ Date: _____

May we leave a message for you on your answering machine or voicemail?

_____ Yes** _____ No

**If yes, please specify who we are able to leave messages with: _____

Appointment Reminder/Contact Consent

By listing my cell phone number and/or email address below, I am agreeing to receive text messages and/or email messages from Northwest Suburban Medical Associates. I am consenting to recurring contact from Northwest Suburban Medical Associates regarding appointment reminders, phone calls, or email reminders and patient feedback surveys. I understand that my telephone company may impose charges on me for these contacts. I understand that I may revoke this consent at any time.

Cell Phone: _____

Email Address: _____

Signature: _____ Date: _____