Patient Consent and Clinic Policies of S. Overduin Medicine Professional Corporation ("the Clinic")

This document aims to explain certain aspects of how care is provided at the Clinic and document specific consents where required. It does not replace the process of informed consent, established through discussion with your physician as part of your care.

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1. Consent to Care

I consent to receive **medical care** from physicians and authorized staff at the Clinic. I understand that informed consent for specific assessments, investigations, or treatments will be obtained through discussion with my physician at the time such care is proposed, including discussion of material risks, benefits, and alternatives. I understand that no guarantee has been made regarding outcomes.

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2. Virtual Care

I understand that appointments may be offered by **video or telephone** if appropriate. I understand that I am not required to receive care virtually and that in-person care remains available. I acknowledge that virtual care may not be suitable for all issues or patients. I understand that I may be advised to attend an in-person visit or seek urgent care if virtual care is not clinically appropriate.

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3. AI-Assisted Clinical Documentation

I understand that the Clinic may use **AI-assisted medical scribe technology** to assist with generating clinical documentation from audio during my visit. I understand that I may decline the use of AI scribe technology by notifying the clinician at the start of the visit, without affecting my access to care. If and when such AI scribe technology is used, I understand that:

- Audio from the encounter may be processed transiently for documentation purposes;
- The Clinic does not retain audio recordings of the encounter;
- The resulting written clinical note forms part of my medical record; and
- My personal health information is protected in accordance with applicable privacy laws.

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4. Privacy and Personal Health Information

The Clinic collects, uses, and discloses **personal health information** in accordance with the *Personal Health Information Protection Act, 2004 (PHIPA)* for purposes including providing care, coordinating care within the circle of care, billing and administrative operations, and meeting legal and regulatory obligations.

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5. Use of Information for Quality Improvement, Education, and Research

I understand that the Clinic may use personal health information, as permitted by law, for **activities aimed at improving patient care** including quality improvement, quality assurance, risk management, education, and passive research activities. Specific activities may include reviewing clinical outcomes, evaluating or improving clinical processes, and developing or refining clinical tools, decision-support resources, or software intended to support patient care. Where feasible and appropriate, the Clinic will minimize identifying information and use de-identified or aggregated information for these purposes, in accordance with applicable legal, regulatory, and professional requirements. I understand that some activities may be permitted without express consent under PHIPA, while others may require additional consent or approvals, which will be addressed separately where required. Information will not be used for commercial marketing or disclosed externally in an identifiable form without appropriate authorization.

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6. Appointments, Missed Appointments, and Uninsured Services

Appointment times are reserved specifically for me. If I fail to attend a scheduled appointment or cancel or reschedule without reasonable notice, I understand that the Clinic may charge a reasonable **no-show or late-cancellation fee** to compensate for lost clinical time. These fees are not covered by OHIP or private insurance. Fees will not be charged where non-attendance is due to circumstances beyond my control, as reasonably determined by the Clinic. I understand that some services (such as form completion or administrative services) may not be covered by OHIP and may be billed directly to me.

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7. Communication

I consent to the Clinic **contacting me** for purposes related to my care and clinic administration. I understand that the Clinic will use secure communication methods where appropriate and available. I understand that I may discuss my communication preferences with the Clinic and that no electronic communication method is entirely risk-free.

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8. Acknowledgement

I acknowledge that I have read and understood this document, have had the opportunity to ask questions, and understand that I may withdraw or limit certain consents, or request restrictions on the use or disclosure of my personal health information, subject to legal and professional requirements.

Patient Name: _____ **Signature:** _____

Substitute Decision-Maker (if applicable): _____ **Date:** _____