KEITH D. JORGENSEN, MD, PROF. ASSOC. and PROF. HEARING MANAGEMENT
44 BIRCH STREET, SUITE 304
DERRY, NH 03038

PATIENT NAME: _____DATE OF BIRTH:_____

Patient Consent:

I authorize the providers of Keith D. Jorgensen MD PA and Professional Hearing Management to administer any treatment, perform procedures and/or radiological services as deemed necessary in the diagnosis and treatment of the patient named above.

I authorize Keith D. Jorgensen MD PA and Professional Hearing Management employees and providers to utilize my home or work phone numbers and answering machine(s) for the purpose of disclosing appointment and/or treatment information.

I authorize assignment of insurance benefits to Keith D. Jorgensen MD PA and Professional Hearing Management for the purpose of payment towards services rendered by Keith D. Jorgensen MD PA and Professional Hearing Management. Keith D. Jorgensen MD PA and Professional Hearing Management will submit claims to my insurance carrier on my behalf, and will accept payment in accordance with contractual obligations.

I acknowledge receipt of the "Notice of Privacy Practices" and consent to the use and disclosure of medical records (including records pertaining to drug and/or alcohol use, mental health, sexually transmitted disease, HIV/AIDS testing/treatment and/or other sensitive information).

I acknowledge that Keith D. Jorgensen MD PA and Professional Hearing Management electronic health information records will be accessible to a limited number of staff to facilitate accurate and timely communication of information necessary to provide services ordered by Keith D. Jorgensen MD PA and Professional Hearing Management providers.

I understand that some insurance carriers require that I obtain an insurance referral from my primary care provider for specialty care services prior to having medical services rendered. I acknowledge that if I do not have a referral for today's visit that I will assume full financial responsibility for the services rendered if my insurance company denies my claim for these services. I understand that there are some specialty services that may not be covered by my insurance carrier, and that I will be fully responsible for those services.

I agree that Keith D. Jorgensen MD PA and Professional Hearing Management may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature:_____Date:_____
Patient/parent/guardian signature and relationship to patient

Disclosure of Information:

If you would like us to be able to discuss and disclose your medical care and/or billing account information with anyone other than yourself, please list the name, relationship, and telephone number below.

_____

Name Relationship Telephone #

_____

Name Relationship Telephone #