SOUTH JERSEY HEARING AND TINNITUS
HEAR THE MOMENTS THAT MATTER MOST

856-386-8150
kelli@sjhearing.com
217 Laurel Heights Drive
Bridgeton, NJ 08302

Consent for Treatment

I consent to receive audiological services from South Jersey Hearing and Tinnitus, LLC. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from South Jersey Hearing and Tinnitus, LLC.

Patient Signature_____ Date _____
Guardian/Power of Attorney Signature_____ Date _____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Patient Signature_____ Date _____

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to South Jersey Hearing and Tinnitus, LLC for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. This is to serve as a long-term authorization card.

Patient Signature_____ Date _____

I acknowledge I have received and have read the notice of privacy practices for South Jersey Hearing and Tinnitus, LLC. I can request a copy at any time for my records.

Patient Signature_____ Date_____