GI Associates of New Hampshire

60 Commercial Street, Suite 404
Concord, NH 03301
Phone: 603-228-1763 Fax: 603-228-7088

A COLLABORATIVE PRACTICE BETWEEN

CONCORD GASTROENTEROLOGY, PA
- Robert D. Thomson, MD
- Samuel C. Somers, MD
- Robert J. Chehade, MD
- Marcy G. Southwell, PA-C
- Jessica A. Perrone, PA-C

DARTMOUTH-HITCHCOCK
- Michael J. Gilbert, MD
- Burr J. Loew, MD
- Scott R. Oosterveen, MD
- Leyla J. Ghazi, MD

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I ______________________________ acknowledge receipt of the Notice of Privacy Practice
Please Print Patient's Name

for PHI from GI Associates of N.H., Dartmouth Hitchcock Concord, Concord Gastroenterology, P.A. I understand this notice contains important information about how my medical information may be used and disclosed and how I can get access to this information.

CONSENT FOR TREATMENT

I consent to routine treatment deemed necessary or advisable by the health care provider responsible for my care. I also understand I have a right to be informed about all treatments given me and the right to decline any specific treatment should I so choose.

____
Signature

____
Date of Birth

____
Date

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Consent to Discuss Medical and Payment Information

I authorize Concord Gastroenterology, Dartmouth Hitchcock or its representatives to speak with the family members/friends listed below

Name:	**Relationship:**	**Phone #:**
What can be discussed with or released to this person:		
❑ **No Restrictions (all of my medical & billing information can be discussed with this person)**		
❑ Appointment Information	❑ Medical Conditions	❑ Test Results
❑ Prescriptions/Sample Medications	❑ Billing Information	❑ Correspondence

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______ I only want medical information given to myself personally.

____ ________________

Signature of Patient or Legal Guardian **Date**

VOICEMAIL: I give permission for the office staff to leave information such as but not limited to appointment information, billing information, test results or to return a call to the office, on an answering machine and/or voicemail at:

Home #:	**Work #:**	**Cell #:**

____ ________________

Signature of Patient or Legal Guardian **Date**

I hereby authorize payment directly to Concord Gastroenterology/Dartmouth Hitchcock, of the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referrals and/or authorizations from my primary care and/or referring physician when required. I also authorize release of any information relating to my medical claim.

____ ________________

Signature of Patient or Legal Guardian **Date**