



Site information/Label Site: _____ Address: _____ _____
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Consent to Treat/Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I understand and agree that RGAL Anesthesia Services, LLC, an affiliate of US Digestive Health may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations.

I authorize the release of any medical information necessary to process my claims to the insurance companies/carriers listed in my file. I authorize and assign payment of medical benefits on my behalf directly to RGAL Anesthesia Services, LLC. A copy of this authorization will be as valid as the original.

Signature of Patient or Authorized Representative

Date

Relationship to Patient