Consent to Treat/Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I understand and agree that Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. 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 Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health. A copy of this authorization will be as valid as the original.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient