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

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Relationship to Patient