



Patient Name: _____ Date of Birth: _____

TREATMENT CONSENT AND ASSIGNMENT OF BENEFITS

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

Signature of Patient or Authorized Representative Date

Relationship to Patient

NOTICE OF PARTICIPATION IN QHIN

US Digestive Health participates in CommonWell through PrismaNet. It is a QHIN (Qualified Health Information Network) to facilitate the secure exchange of your health information, including information related to mental health diagnoses and procedures, between and among your health care providers for purposes related to treatment, payment, healthcare operations, and secondary use. Through our connection to the CommonWell QHIN, we will share your health information with other participating health care providers for our Patients to provide faster access, facilitate better coordination of care, and enable more informed care decisions. You may choose to “opt out” and not have any of your health information shared through the QHIN by completing and submitting the Opt Out Request Form to your medical provider. You may ask your provider for a copy of the Opt Out Request Form, or email to Compliance@USDHealth.com.

AGREEMENT AND ACKNOWLEDGMENT OF VENUE

NOTICE: Venue Selection Clause. As a patient, or authorized representative on behalf of a patient, of US Digestive Health, and in consideration for treatment received through or care provided at any US Digestive Health location, I knowingly and voluntarily agree that any claim, dispute, civil action, or proceeding, including any claim of negligence or medical malpractice in any way related to this admission/procedure and medical services, shall be brought exclusively in the Court of Common Pleas of the County where services were rendered by US Digestive Health, in the Commonwealth of Pennsylvania. I further voluntarily, knowingly, and expressly waive the right to object to venue in the county in which I received services and waive the right to file or assert any claims or disputes against US Digestive Health, its affiliates, employees, officers, or agents in any other county.

Signature of Patient or Authorized Representative

Date

Relationship to Patient