CENTER FOR DIGESTIVE HEALTH AND NUTRITION
AND
THREE RIVERS ENDOSCOPY CENTER
General Consent and Release Form

CONSENT FOR TREATMENT

I,_____, on behalf of _____ consent to medical evaluation and treatment by the physicians and employees of the Center for Digestive Health and Nutrition, PC and Three Rivers Endoscopy Center, Inc. I understand that my medical evaluation and treatment may include certain diagnostic tests. In addition, my physician or may determine that certain invasive procedures are necessary. I understand that I may discuss my medical treatment with my physician and may withdraw my consent if I so desire.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

1. I agree to the following terms with respect to payment for all services provided:
    A. I authorize the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center to bill my insurance carrier and request such payments be made directly to the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center.
    B. I certify that the information given by me with respect to insurance coverage or other payment sources is correct.
    C. I assign the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center all rights to insurance payments or other benefits to which I may be entitled for the services rendered.
    D. I authorize the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center to release any medical information about this treatment or service, if required, in order to obtain payment from my insurer or other payor as well as any such records or information as may be required by my insurer.
2. I understand that any amounts not paid by my insurance, including co-payments and deductibles, are my responsibility. I agree to pay the full charge for all services rendered by the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center at the time of service.

    **Upon your request, a patient Account Representative will discuss charges you will encounter for services provided to you.*

MEDICARE LIFETIME ASSIGNMENT (If applicable)

I request that payment of authorized Medicare benefits be made on my behalf to the Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

HIPAA ACKNOWLEDGEMENT/RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been provided with the Notice of Privacy Practices for the Center for Digestive Health and Nutrition, and Three Rivers Endoscopy Center on _____(date). The Center for Digestive Health and Nutrition and/or Three Rivers Endoscopy Center is authorized to use and disclose health information about _____(patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices. I understand that my information may be released if required by law.

I have read this General Consent and Release Form or have had it read to me, and it has been explained to my satisfaction.

Signature of Patient_____ _____Date_____

Signature of Personal Representative_____Date_____

Name of Personal Representative_____Relationship to Patient_____

Guarantor for Financial Arrangements _____Relationship to Patient_____