

**PATIENT SIGNATURE STATEMENT**

The information presented here enables you to consent for needed medical care services, as well as for the release of information from your medical records for medical and administrative purposes.

**CONSENT FOR TREATMENT:** I am presenting myself for outpatient care at The Digestive Health Clinic, LLC and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of The Digestive Health Clinic, LLC and by medical staff or their designees as in their professional judgment may be deemed necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this Clinic.

**RELEASE OF INFORMATION:** I authorize The Digestive Health Clinic, LLC to release to the third party payer named in my registration, or a designated review agency, any information from my medical record, including information about my treatment, which is needed for the purpose of processing my claim. I also authorize The Digestive Health Clinic, LLC to release to a referring physician information about my treatment and progress. I reserve the right to withdraw either authorization at any time, which can only be effective with my written consent.

**MEDICARE OR TRICARE ONLY:** I request payment of authorized benefits be paid to The Digestive Health Clinic, LLC on my behalf for any services furnished to me by or in The Digestive Health Clinic, LLC including physician services. I authorize any holder of medical and other information about me to release to Medicare or Champus and its agents any information needed to determine these benefits for related services.

**ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT:** I hereby authorize payment directly to The Digestive Health Clinic, LLC of all insurance benefits, not to exceed charges, to which I would otherwise be entitled for these services. I understand and agree regardless of my personal ability to pay, that I am financially responsible to The Digestive Health Clinic, LLC for charges not covered by insurance.

**PERSONAL VALUABLES:** It is understood and agreed that The Digestive Health Clinic, LLC shall not be liable for the loss of or damage to any money, jewelry, documents, fur garments, or other articles of unusual value.

**IDAHO ENDOSCOPY CENTER:** It is understood that the Idaho Endoscopy Center is owned by, and operated as a part of the practice of, the physicians of The Digestive Health Clinic, LLC. I understand that I may choose to have certain gastroenterology or endoscopic procedures done at the Idaho Endoscopy Center or at either St. Lukes Regional Medical Center or St. Alphonsus Regional Medical Center.

**I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date/time

\_\_\_\_\_  
Responsible Person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness