CENTER for DIGESTIVE MEDICINE

Patient Financial Consent

Deductibles may be applied to *Center for Digestive Medicine, PLLC* or *Gastro Anesthesia Services, LLC*, creating an overpayment.

I, _____, authorize *Center for Digestive Medicine, PLLC* or *Gastro Anesthesia Services, LLC* to reimburse each other directly if my deductible has not been met at either entity.

_____ _____

Patient Signature Date

_____

Consentimiento del Paciente Financiera

Deductibles pueden ser aplicados a *Center for Digestive Medicine, PLLC* o *Gastro Anesthesia Services, LLC*.

Yo, _____, autorizo *Center for Digestive Medicine, PLLC* o *Gastro Anesthesia Services, LLC* reembolsarse mutuamente si mi deducible no hubiera sido cubierto en una de las facilidades.

_____ _____

Firma del Paciente Fecha