CEDAR VALLEY
Digestive Health Center

Treatment Consent

I authorize you to give me reasonable and proper medical care by today's standards.

I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.

I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.

I understand that I am responsible for any balance due on my account.

I authorize that a copy of this information to be as valid as the original.

Signature _____ Date _____