3311 Prescott Road, Suite 411
Alexandria, LA 71301
(318)448-5310

MEDICAL BENEFITS/PRIVACY PRACTICE

Patient: ____________________________________ Date: ________________________________

I request that payment of authorized **Medical Benefits** be made either to me or on my behalf to Alexandria GastroIntestinal Specialists for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of Patient or Guardian: __________________________________Date:_____________

I acknowledge that I have received the **Notice of Privacy Practice** from Alexandria GastroIntestinal Specialists and it is my responsibility to read its contents.

Signature of Patient or Guardian: _________________________________Date:______________