ROLLER
WEIGHT LOSS &
ADVANCED SURGERY

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PAYMENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize treatment of the person names below and agree to pay all fees and charges for such treatment promptly upon receipt of statement unless credit arrangements are agreed upon in writing. Charges shown on statements are agreed upon to be correct and reasonable unless protested in writing within thirty (30) days of billing date.

In the event that I default on payment(s) due for medical services rendered, I agree and understand that I will be responsible for collection fees/cost incurred by Roller Weight Loss and Advanced Surgery when the account is turned over to collections. I agree that the information given on the Patient Statistical Information forms is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

In the event of insurance:
In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Roller Weight Loss and Advanced Surgery all medical benefits and/or reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under law and under applicable insurance policies and employee health care plan, chose in action, or other right I may have to such insurance or employee health care benefit coverage under any applicable insurance policies and employee health care plan with respect to medical expenses incurred as a result of the medical services I receive from above medical practice and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the above mentioned medical practice in any attempt to pursue such claim, chose in action or right against my insurers or employee health care plan in my name but as such doctors and clinic's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed name of Patient Patients Date of Birth

Official General Surgeon
for the Arkansas Razorbacks®