ROLLER
WEIGHT LOSS &
ADVANCED SURGERY

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To Whom it May Concern

I, _____ am a patient/legal guardian of Roller Weight Loss and Advanced Surgery. I fully understand that any recommendation made to me in regard to surgical treatment, diagnostic treating, hospitalization, follow-up appointments, physician referral or prescribed therapy (medicinal, physical, dietary and/or environmental) by the physicians and/or staff of Roller Weight Loss and Advanced Surgery is made in the best interest of the patient. Failure to follow through with the recommendation and any consequence thereof is solely my responsibility.

I also understand that there will be a $25 no show fee for any appointments not cancelled within 24 hours prior to the scheduled appointment time.

Nutritional Provider Services
Insurance **DOES NOT** cover nutritional services for weight loss. If we billed insurance the charge **would be $54**, which would be **non-covered services** and therefore you would be responsible for the full amount. Since your insurance requires that you have non-surgical weight loss attempts documented by a physician and a nutritionist we have Discounted the fee for nutritional services to **$15**.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed name of Patient Patients Date of Birth