

Consent to Treatment

To Whom It May Concern:

I, _____, a patient of Roller Weight Loss & Advanced Surgery, fully understand that any recommendation made to me in regard to surgical treatment, diagnostic treatment, 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 & 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.

PATIENT'S SIGNATURE

DATE

WITNESS


Official General Surgeon
for the Arkansas Razorbacks®

ROLLER
WEIGHT LOSS &
ADVANCED SURGERY



Center of
Excellence
BARIATRIC SURGERY