REALEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes Aesthetics and Weightloss, LLC to release any and all medical information to their health insurance company(s), or other physicians or hospitals involved in the treatment of said patient or to any other individuals relative to health care provider operations. The undersigned does specifically authorize release of said information in accordance with the HIPAA Privacy Act. I also authorize payment directly to Aesthetics and Weightloss, LLC for all medical benefits, if any, otherwise payable to me for the services rendered by Aesthetics and Weightloss, LLC.

ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT OF ACCOUNTS AT THE TIME SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS ARE APPROVED.

The medical provider will file insurance claims on your behalf, but is not an insurer of said claims, and it is the patient/responsible party's duty to handle all matters with their insurance company in reference to payment of claims.

The undersigned understands that they are fully responsible for the charges associated with the treatment, and further agrees that in the event this account is placed for collection, they will be responsible for all collection charges, including a reasonable attorney fee and interest. The undersigned also waives any rights which they may have according to the Constitution and Laws of the State of Alabama, or any other state, to claim exemptions as to personal and or real property as provided by the Constitution and Laws of the State of Alabama, or any other state.

SIGNATURE DATE

RESPONSIBLE PARTY SIGNATURE DATE