SLEZAK COLORECTAL SURGICAL CLINIC, PL

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments, otherwise payable to me for services rendered by Lori Ann Slezak, M.D. and staff payable to and mailed directly to:

Slezak Colorectal Surgical Clinic, PL
4814 Habana Ave
Tampa, FL 33614

Furthermore, I hereby IRREVOCABLY ASSIGN to Slezak Colorectal Surgical Clinic, PL the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges, provided by Slezak Colorectal Surgical Clinic, PL.

Furthermore, the undersigned by these presents does hereby make, constitute and appoint Slezak Colorectal Surgical Clinic, PL and any of its duly authorized agents and employee as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Slezak Colorectal Surgical Clinic, PL's which checks, drafts or money orders are made payable for services which have been made by Slezak Colorectal Surgical Clinic, PL, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Slezak Colorectal Surgical Clinic, PL or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

MEDICAL RELEASE

Furthermore, a photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Slezak Colorectal Surgical Clinic, PL's or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

CONSENT TO TREAT

I authorize Slezak Colorectal Surgical Clinic, PL to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved and the possibilities of complications have been fully explained to me.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20____.

PATIENT'S SIGNATURE	PATIENT'S PRINTED NAME	DATE
WITNESS SIGNATURE	PRINTED NAME	DATE