



Consent to Treat

TeamWork Health PLLC provides comprehensive Pulmonary and Sleep Medicine services. By signing below, I, the Patient or Patient's Legal Representative, consent to the evaluation and treatment recommended by the provider(s) involved in my/the patient's care.

1. Consent to General Medical Evaluation and Treatment

I authorize TeamWork Health PLLC's physicians, advanced practice providers, respiratory therapists, sleep technologists, and clinical staff to perform examinations, evaluations, diagnostic procedures, and treatments deemed necessary or advisable for my/the patient's care. This includes routine office visits, physical examinations, review of medical history, and related clinical services.

2. Diagnostic & Therapeutic Procedures

I understand that, based on my condition, my provider may recommend one or more of the following services:

- Pulmonary Testing & Procedures
 - Pulmonary Function Testing (PFTs), including spirometry, lung volumes, and diffusion capacity
 - Six-Minute Walk Test
 - Arterial Blood Gas (ABG) collection
 - Methacholine Challenge Testing (airway responsiveness testing)
 - Cardiopulmonary Exercise Testing (CPET)
- Sleep Medicine Testing
 - Home Sleep Study (HST)
 - In-Lab Sleep Study (Polysomnogram) with or without PAP titration
 - Overnight monitoring and associated video/audio recording when performed in-lab
- Laboratory & Ancillary Services
 - Collection of blood, urine, or other specimens
 - Diagnostic measurements related to respiratory or sleep evaluation

3. Risks and Limitations of Testing

I understand that the purpose, benefits, and potential risks of recommended procedures will be explained to me, and I may ask questions at any time. While serious complications are rare, there are possible risks. Staff will follow established safety protocols, and emergency equipment is available when applicable.

4. Right to Refuse or Withdraw Consent

I understand that I may refuse any recommended test or treatment and may withdraw my consent at any time, except where care has already been provided based on my prior consent.

5. Questions and Understanding

I acknowledge that I have had the opportunity to ask questions about my/the patient's condition, the recommended tests or treatments, and any associated risks. All questions have been answered to my satisfaction.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ **Date:** _____

*Please call (919) 238-1110 if you have questions regarding this policy document.
For questions regarding your bill, please e-mail billing@twhasg.com.*