Authorization & Assignment of Benefits

Instructions: Please complete all sections of this Authorization & Assignment of Benefits form. If any sections are left blank, this form will be invalid, and you will be responsible for submitting claims to your insurance company and for full payment of services at time of service.

Patient Full Name: ______________________________

Patient Date of Birth: ______________________________

I, the undersigned patient or legally authorized representative, hereby assign and authorize direct payment of all medical and insurance benefits to TeamWork Health PLLC for services provided to me. This assignment includes, but is not limited to, major medical, Medicare, Medicaid, private insurance, and any other health plans.

I understand that:

1. This assignment of benefits will remain in effect until revoked by me in writing.
2. I am financially responsible for any charges not covered by my insurance, including co-pays, deductibles, and non-covered services.
3. TeamWork Health PLLC may release any necessary medical information to my insurance carrier or other relevant third parties to process claims.
4. If my insurance company sends payment directly to me, I will promptly remit such payment to TeamWork Health PLLC.

I authorize TeamWork Health PLLC to act on my behalf to appeal insurance denials or underpayments.

I certify that the insurance information I have provided is accurate and that I understand my financial responsibility for medical services rendered.

Patient/Authorized Representative Signature: ______________________________

Date: ______________________________

We encourage those who have questions regarding this policy document to contact us at ***919-238-1110.***
For questions regarding your bill, please e-mail **billing@twhasg.com**.