TEAMWORK HEALTH
BETTER TOGETHER

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

_____ **Consent to Treat**
I, the Patient/the Patient's Legal Representative, hereby grant permission to TeamWork Health PLLC and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

_____ **Notice of Privacy Practices**
I understand that TeamWork Health PLLC will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Authorization and Assignment of Benefits**
I authorize the payment of medical benefits to TeamWork Health PLLC, and hereby assign to TeamWork Health PLLC and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Release of Billing Information**
I authorize TeamWork Health PLLC to release any billing, account, and insurance-related information necessary to process claims and obtain payment for services rendered. This includes disclosure to Medicare, Medicaid, and any private or supplemental insurers involved in my coverage. I understand this authorization remains in effect until I revoke it in writing.

_____ **Patient Payment Policy**
I have read and understand the TeamWork Health PLLC Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Patient Rights and Responsibilities**
I understand that I have the right and responsibility to participate in my/the patient's care and to be informed about recommended treatment. I will ask questions when I need clarification and provide accurate, complete health information so an appropriate care plan can be created and followed. I also understand that TeamWork Health PLLC providers will treat me with respect, and I agree to treat them with the same respect.

Patient Name (printed): _____

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

*We encourage those who have questions regarding this policy document to contact us at **919-883-1583.***
*For questions regarding your bill, please e-mail **billing@twhasg.com**.*