TRIANGLE
WELLNESS & RECOVERY

CONSENT FOR TREATMENT

This consent will be effective for 1 year after the date it is signed at Triangle Wellness & Recovery PLLC and will not expire for services or visits while this consent is/was in effect.

Acknowledgement of Notice of Privacy Practices - HIPAA

The Notice of Privacy Practices is a complete description of my privacy rights as a patient of Triangle Wellness & Recovery PLLC. By signing below, I am stating I have received Triangle Wellness & Recovery PLLC's NOTICE OF PRIVACY PRACTICES.

Acknowledgement of Patient & Client Policies

The Triangle Wellness & Recovery PATIENT & CLIENT POLICIES describes our policies with regard to New Patient Registration, Appointments, Scheduling, Late Arrival, Cancellation, No Call/No Show Appointments, Checking In, Payments and Communications. By signing below, I am stating I have received Triangle Wellness & Recovery PLLC's PATIENT & CLIENT POLICIES.

Consent for Treatment / Care

I consent to treatment and care by Triangle Wellness & Recovery PLLC by their medical, psychiatric, mental health and other health care providers. I understand that my treatment and care may include a variety of medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health provider. I am aware that the practice of medicine is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Financial Information

I give permission for Triangle Wellness & Recovery PLLC, including its treating and referring providers and other staff members, to release any information for my health services that may be necessary for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or for the health care operations of Triangle Wellness & Recovery PLLC. For more detailed information about the way my information may be used or released, I can read the Triangle Wellness & Recovery PLLC's Notice of Privacy Practices.

I have read and understand the permissions and disclosures above and hereby give Consent.

Patient / Authorized Signature	Date

Patient Name - Printed	Relationship to Patient (If not self)