



SERVICES AUTHORIZATION FORM

CONSENT TO TREAT

The information I have provided on the registration form is true and correct to the best of my knowledge. Based on this, I wish to register as a Valley Health Team, Inc. patient. I give my consent to all services ordered by the attending physician when appropriately informed of the reason and consequences of said services.

Signature of Patient, Parent or Legal Guardian

Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Valley Health Team, Inc. to release any information acquired in the course of my examination or treatment.

Signature of Patient, Parent or Legal Guardian

Date

AUTHORIZATION TO PAY BENEFITS

I hereby authorized payment of benefits to which I am entitled, directly to Valley Health Team, Inc.

Signature of Patient, Parent or Legal Guardian

Date