**CONSENTS, AUTHORIZATIONS AND GUARANTEES**

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**Patient’s Name (Last, First)** **Date of Birth**

By signing this consent, I certify that I have reviewed and agree to the terms and provisions of the Advanced Brain and Body Clinic, PLLC (ABBC) Notice of Information Practices. The following is a summary of those terms and provisions. If I have any questions, I have received satisfactory answers before signing this Consent.

I understand that some things, by law, cannot be kept private. The exceptions to confidentiality are as follows, including but not limited to: If ABBC is ordered to testify in, or provide documents to, a Court of Law, they may have to give information regarding my case without my permission. If ABBC learns that harm has been done to a child or an elderly person, they may be required to inform the authorities. If ABBC learns that someone or something might be seriously harmed in the future, or that a patient intends to commit an act of violence, it may be ABBC responsibility to protect me, or others, by informing them and the authorities. If I am being treated under a Worker Compensation claim, and/or if there are indications of a need for other specialized treatment, necessary PHI may be released to an appropriate referral provider to facilitate this treatment.

## Consent and Authorization for Treatment and Scheduling of Appointments

I hereby authorize ABBC and its professional staff to provide treatment to myself, or the person named above for whom I am legally responsible for medical and/or financial decisions, to include psychiatric assessments, medication management, and/or other mental health services. **I understand I am to notify ABBC of a request to cancel an appointment 24 hour prior to the time of the appointment to be canceled. If I fail to make such timely notification, ABBC may refuse to schedule future appointments.**

**I explicitly authorize ABBC to use or disclose my protected health information to contact me to remind me of appointments. ABBC may call my contact phone number(s) and leave messages to remind me of the time and date of my next appointment at MBBH.**

**Explicit Consent and Authorization for Use and Disclosure of Protected Health Information (PHI)**

In signing this form, I do hereby consent and authorize ABBC to the use and disclosure of my Protected Health Information by ABBC, its staff, and its business associates for the purpose of treatment, payment, and health care operations as detailed in its current Notice of Information Practices. I have reviewed the ABBC Notice of Information Practices prior to signing this consent/authorization form and have received a copy if I so request. I understand the ABBC Notice of Information Practices may change at MBBH’s discretion, as necessary.

# I understand that by completing an ABBC Request to Restrict use and Disclosure of PHI Form, I may request that restrictions can be placed on how my protected health information is used and disclosed. We have the right, however, to deny your request. You may also revoke this consent, in writing. Information on treatment and services provided on prior consents may still be used for purposes of treatment, payment, or health care operations. Please refer to the ABBC Notice of Information Practices for further information.

**Patient or Legal Guardian Signature**  **Date**

**Authorization of PHI Disclosure and Assignment of Health Plan Benefits**

I explicitly authorize and request ABBC, as a holder of PHI and other information about myself, or the person named above for whom I am legally responsible for medical and/or financial decisions, to release to the Medicare, or any other health plan any information needed to determine benefits or pay claims on my behalf. This PHI may include psychiatric and/or psychotherapy notes, unless specifically prohibited by me. I request that payment of all health plan benefits to be made to on my behalf, directly to ABBC. PLEASE NOTE: Should you refuse to allow release of records to insurance for the purpose of paying a claim, the fees for the services in question will become YOUR RESPONSIBILITY.

**Guarantee of Payment, Authorization of PHI Disclosure and Assignment of Patient Due Balances**

**I understand, and hereby guarantee, that I will pay the patient portion of fees incurred that day, and any balance due at time of service, unless prior arrangements have been made**. I hereby authorize ABBC to assign any balance due charges, for which I am responsible, to any of its business associates for the purpose of collecting such charges. I further understand that I am responsible for any and all ABBC’s usual and customary charges not paid by my health plan, except those contractually discounted.

***I understand all these authorizations will remain effective for one year after I have stopped being an active patient of MBBH.***

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**Patient or Legal Guardian Signature** **Date**

[ ] check here if Legal Guardian. Copy of Court Order MUST be attached for authorization to be valid

**Print Name of Signature:**