Advanced Primary & Behavioral Health, LLC

Assignments and Authorizations

Patient Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

The consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or Nurse Practitioner, Physician Assistant, or Clinical Nurse, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedures(s).

FINANCIAL RESPONSIBILITY

Subject to applicable law and the terms and conditions of any applicable contract between this office or third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay Advanced Primary & Behavioral Health, LLC for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to me (or the abovenamed patient), I agree to be financially responsible and obligated to pay Advanced Primary & Behavioral Health, LLC for the patient balances due.

ASSIGNMENT OF BENEFIT

In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign Advanced Primary & Behavioral Health, LLC all right, title, and interest in and to any third-party benefits due from all insurance policies and/or responsible third-party payers. I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with Advanced Primary & Behavioral Health, LLC for my insurance to be billed and as such I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide Advanced Primary & Behavioral Health, LLC with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

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CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient of Advanced Primary & Behavioral Health, LLC, I authorize the office to retrieve and use my medication history from SureScripts, an electronic prescriptions network. This is an electronic way for Advanced Primary & Behavioral Health, LLC. to access patient prescription benefit information and patient medication history. Advanced Primary & Behavioral Health, LLC can only retrieve medication history from offices that support SureScripts. Utilizing this method is the best way to obtain the most up to date information so that your healthcare provider can deliver the best care to you.

NOTICE OF PRIVACY PRACTICE

I have received or been offered a copy of the Notice of Privacy Practices for Advanced Primary & Behavioral Health, LLC. The Notice of Privacy Practices explains how the office may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let Advanced Primary & Behavioral Health, LLC use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by Advanced Primary & Behavioral Health, LLC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Advanced Primary & Behavioral Health, LLC or provide assistance to Advanced Primary & Behavioral Health, LLC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above-named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that Advanced Primary & Behavioral Health, LLC has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to Advanced Primary & Behavioral Health, LLC or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from Advanced Primary & Behavioral Health, LLC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from Advanced Primary & Behavioral Health, LLC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

_____ _____

Patient/Legal Guardian Signature **Relationship to Patient**

_____ _____

Witness Signature **Date**