BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Consent and Financial Responsibility

I consent to the use or disclosure of my protected health information by Bio-Behavioral Medical Clinics, Inc. (BBMC, Inc.) for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of BBMC, Inc. I understand that diagnosis or treatment of me by BBMC, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. BBMC, Inc. is not required to agree to the restrictions that I may request. However, if BBMC, Inc. agrees to restriction that I request, the restriction is binding on BBMC, Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that BBMC, Inc. has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "*Notice of Privacy Practices"* describes how BBMC, Inc. may disclose and use my protected health information (PHI). I am encouraged to read the "*Notice of Privacy Practices"* in full.

BBMC, Inc. requires 24-hour advance notice of appointment cancellation. You may contact the office Monday through Thursday, 9:00AM to 5:00PM or Fridays, 9:00 AM to 12:00 PM. You may also leave a message with our answering service.

Financial Responsibility:

- Co-pays or deductibles are due at time of service.
- A minimum of $20.00 will be collected on all services with a deductible or where a deductible applies. Applicable adjustments will be made once your insurance carrier has paid for services rendered.
- Past due accounts will be sent to a collection agency and the patient will be discharged from practice.

A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance plan. If any amount is assigned for collections and/or legal action is required, the prevailing party shall be entitled to reasonable attorney's fees and court costs. I hereby authorize said assignee to release all information necessary to secure payment.

Printed Name: _____
(patient/representative/guardian)

Signature: _____ Date: _____