BEHAVIOR MANAGEMENT SYSTEMS, INC.

PATIENT: ____

RESPONSIBLE PERSON: ____

RESPONSIBLE PERSON'S RELATIONSHIP TO PATIENT: __________________________

Insurance Authorization

I acknowledge that Behavior Management Systems, Inc.(BMS) will file insurance claims on my behalf. I authorize assignment of benefits and further give permission for BMS to release information to my insurance company if requested.

_______________________________________ _______________________
Signature Date

Notice of Privacy Practices

In compliance with the state and federal requirements of HIPAA I have been provided with a copy or access to Behavior Management System's policy and procedures regarding the protection, security, and release of my Protected Health Information.

_______________________________________ _______________________
Signature Date

Scheduled Appointments

I understand and agree to pay for the cost of appointments that I miss if I have not provided Behavior Management Systems with a notice of my intention to cancel within twenty-four (24) hours of the appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments.

_______________________________________ _______________________
Signature Date

Billing and Payment for Services

I understand and agree to pay for services at the time they are provided, unless I have agreed otherwise or unless my insurance coverage requires another arrangement. Further, I agree to pay for all agreed to services that **might not be** covered by my insurance plan including non-covered diagnoses or procedures (e.g., testing (educational, psychological, neuropsychological), biofeedback, hypnotherapy, marital counseling).

_______________________________________ _______________________
Signature Date