Behavioral Health Care, P.C.

300 Country Pine Lane, Battle Creek, MI 49015
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HIPPA CONSENT

CONSENT FOR TREATMENT: I request and consent such care and treatment, as my physician considers necessary. I authorize the performance of diagnostic tests, including lab test, X-rays, and other medical procedures as are recommended by my physician. I consent admission to the Behavioral Health Care, P.C. (BHC, P.C.) and permit my physician and other consultants to provide the necessary care and service for me.

NO GUARANTEE OR PROMISE OF RESULTS AND BHC, P.C. RIGHT TO DISCHARGE: I understand that the practice of medicine is not an exact science. I acknowledge that no one has or can give me promise or guarantee of what the results of my treatment and care will be. I understand that my admission and continued care is based on my physician's determination of my need for services and my compliance with the BHC, P.C. policies. When the attending physician determines that I no longer require continued care and may be discharged, I will cooperate and arrange for discharge from BHP, P.C. Further, I agree that nothing in this understanding prevents the BHC, P.C. from discharging me immediately if I violate the BHC, P.C. policies.

PHYSICAL ENVIRONMENT AND PERSONAL BELONGINGS: I understand that I may not have or bring into BHC, P.C. any illegal drugs, toxic substances, dangerous articles, weapons or alcoholic beverages. I understand that if I do this, I will immediately be discharged from BHC, P.C. I understand that the BHC, P.C. is not responsible for any loss or damage to my personal property.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of insurance benefits (including Medicare or Medicaid) to be made directly to the BHC, P.C. I understand that I am financially responsible for all services incurred at BHC, P.C. by the attending physician/therapists/consultants for services rendered.

RELEASE OF INFORMATION: I authorize the BHC, P.C. to release information from my financial or medical records, to any person or organization, which is responsible for the payment of my bill. I also understand that information relating to drug or alcohol abuse, psychiatric treatment, HIV infection, AIDS, or AIDS Related Complex may be released to parties responsible for payment of my bills. If I am transferred to another facility, copies of my medical records may be released for continued care. This authorization is effective for as long as may be necessary to obtain payment from the third party payer or until I revoke it in writing.

FOR MEDICARE PARTICIPANTS ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Medicare program or its intermediaries or carries or to the Professional Review Organization any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. My signature below only acknowledges the recipient of "an important Message from Medicare" from BHC,

P.C. on the date listed below and does not waive any of my rights to request a review or make me liable for payment.

PRIVACY PRACTICES AND RECIPIENT RIGHTS ACKNOWLEDGEMENT: I understand that I have certain rights that are explained in the written materials that have been provided to me during the registration process. By signing below, I document that my rights as a recipient of services and the federal confidentiality requirements have been provided and explained to my under the HIPPA Law.

SMOKE FREE ENVIRONMENT: I am aware that use of tobacco products at BHC, P.C. is prohibited.

I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND I UNDERSTAND IT. I AGREE THAT BY SIGNING THIS FORM, I AM BOUND BY WHAT IT SAYS, WHETHER I AM THE PATIENT OR SOMEONE ACTING ON THE PATIENT'S BEHALF.

_____	_____
SIGNATURE OF PATIENT OR OTHER PERSON ACTING ON PATIENT'S BEHALF	DATE
_____	_____
RELATIONSHIP TO PATIENT IF SIGNED BY A PERSON ACTING ON PATIENT'S BEHALF	DATE
_____	_____
WITNESS TO SIGNATURE	DATE