Notice of Privacy Practices for Protected Health Information
Effective Date: March 1, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

Action Behavior Centers is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, behaviors, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A behavior analyst may use your health information to provide you with services.
- A behavior analyst may obtain treatment information about you and record it in your client file.
- During the course of your treatment, the behavior analyst may need to consult with other professionals or individuals (e.g., physicians, social workers, educators, family members etc.,). involved in your medical care or treatment. He/she will obtain authorization to share your personal information with these individuals.
- Your health information may be shared with other clinical staff in the company for additional support in developing your treatment program.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other agencies/businesses helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the services provided.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Action Behavior Centers. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by contacting our office -- we are not required to grant the request, but we will comply with any request granted;

- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by contacting our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the office;
    - Is not part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.
- Elect to opt out of receiving further fundraising communications from the office.

If you want to exercise any of the above rights, please make an appointment with your local Office Administrator to make a request in person or in writing, during regular, business hours. He/she will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact your Office Administrator or call our corporate office at 512-572-0157.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our corporate office by mailing the written complaint to 2100 Kramer Lane Suite 150, Austin, TX 78758.

- We cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment from Action Behavior Centers.
- We cannot, and will not, retaliate against you for filing a complaint

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care orin payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation

of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative

proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about clients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Notice of Privacy Practices Acknowledgement

Name of Client:	
Client Date of Birth:	

I acknowledge that I have received a copy of the Notice of Privacy Practices, effective date of March 1, 2017.

Parent / Guardian:	Date:
Signature of Parent/Guardian:	Relationship to Client:

Documentation of Good Faith Efforts
To obtain client's acknowledgement that thy received provider's Notice of Privacy Practices

For use when acknowledgment cannot be obtained from the Client.

On_____/_____/_____, the client was provided with a copy of Notice of Privacy Practices.

A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Client refused to sign
- Client was unable to sign or initial because: _____
- The client had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe): _____

Signature of Employee Completing Form: _____

Date Signed: _____

Informed Consent and Service Agreement

I,_____, as a parent or guardian, give my consent for Action Behavior Centers LLC to provide behavior analytic services to my child or dependent, _____, in accordance with the ethical guidelines proposed by the Behavior Analytic Certification Board (BACB). I also understand that I may withdraw my consent and terminate treatment at anytime and for any reason. I understand that any information provided in this intake as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I understand that Board Certified Behavior Analysts are bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the behavior analyst's area of experience may result in referrals to a more appropriate agency or individual.

Signature of Parent or Guardian:
Date:

Informed Consent for Clinical Diagnostic Evaluation

I,_____(Parent/Guardian), give consent to have my child or dependent, _____ (Child), evaluated or reevaluated for autism spectrum disorder by a Licensed Psychologist at Action Behavior Centers, LLC ("ABC") for the purpose of meeting requirements of my child or dependent's healthcare insurance provider, such as for further testing and/or documentation and/or updating an existing diagnosis.

I understand that this report will be provided directly to my child or dependent's healthcare insurance provider and that the report will also be available to me upon request. I understand that the evaluation will involve some combination of the following: developmental parent interview, review of prior diagnoses and records, a direct measure(s) of autism spectrum and/or related symptoms, and observation.

I also understand that evaluation appointments may be conducted via telehealth. Telehealth refers to providing behavioral health services remotely using technologies, such as video conferencing or telephone in a secure, HIPAA compliant platform. I acknowledge and understand that although all necessary steps will be taken by ABC to ensure confidentiality, there are some potential risks associated with telehealth. For example, I understand that because telehealth sessions may take place outside of a private office, there is potential for other people to overhear sessions if I am not in a private place during the session. Further, I acknowledge and understand that due to the nature of electronic communications technologies there is some risk that electronic communications or data may be compromised, or accessed by others.

I understand that I have the right to revoke this consent upon written notice to ABC.

I also attest that I have read and understand this informed consent form and that I have had an opportunity to ask questions about the evaluation and this informed consent form.

As a biological parent or legal guardian, I represent and warrant that I have the requisite authority to provide consent to the evaluation.

Signature of Parent/Legal Guardian(s):
Date:

Consent for Video Recording for Clinical Diagnostic Evaluation

I,_____(Parent/Guardian), give consent to have my child or dependent, _____ (Child), video recorded and reviewed by an Action Behavior Center, LLC ("ABC") clinician for the purpose of assessment, quality assurance, or training. All video recordings are for internal purposes only.

I understand that I have the right to revoke this consent upon written notice to ABC.

I also attest that I have read and understand this informed consent form and that I have had an opportunity to ask questions about the evaluation and this informed consent form.

As a biological parent or legal guardian, I represent and warrant that I have the requisite authority to provide consent to the evaluation.

Signature of Parent/Legal Guardian(s):
Date:

Authorization for Release and Exchange of Information

I,_____, hereby authorize Action Behavior Centers and the person/organization listed below to release and exchange psychological, educational, medical, and other information about:

Client's Name:	
Date of Birth:	

Person or organization to receive information from Action Behavior Centers:

Name:		
Address (including suite):		
City:	State:	Zip:
Phone:	Fax:	

I understand that this authorization is valid for the period of time in which my child is an active client with Action Behavior Centers. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

Signature:	Date:
Relationship to client:	7 Self 7 Parent 7 Guardian
Signature of ABC Staff:	Date:

Consent for Facility Access or Tour - Privacy Practices Acknowledgement

1. As a person entering the facility or taking a tour of Action Behavior Centers program, I have been informed that Action Behavior Centers is an entity covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy laws.
2. I understand that Action Behavior Centers is committed to providing the highest quality of services while respecting the privacy and confidentiality of the individuals it serves. Despite Action Behavior Centers' efforts to protect the privacy of individuals, during the course of my tour of the program site(s), I may gain access to protected health information ("PHI"), such as an individual's name, address or identification of the types of services an individual is receiving.
3. PHI is defined as individually identifiable health information that is provided orally, on paper, or in electronic form on the computer about an individual's past, present or future physical or mental health or condition; the provision of an individual's health care; or the past, present or future payment for an individual's health care services. PHI also includes any information that identifies an individual such as his/her name, date of birth, or social security number.
4. I understand my responsibilities to maintain the confidentiality of the PHI of the individuals served by the Action Behavior Centers. I understand that I may not use any PHI to which I might gain access during the tour. Specifically, I may not repeat in written, verbal or electronic form any PHI to which I have had access.
5. I understand that if I have any questions about the requirements for safeguarding PHI that the Action Behavior Centers staff person providing the tour is available to answer my questions. I may also contact the Action Behavior Centers Privacy Officer or the Office for Civil Rights at:

Action Behavior Centers
2100 Kramer Lane Suite 150
Austin, TX 78758
(512) 572-0157

Office for Civil Rights
U.S. Department of Health and Human Services
JFK Federal Building – Room 1875
Boston, MA 02203
617-565-1340 or 617-565-1343 (TDD)

Name:	Signature:
Date:	

Insurance Payment Policy and Authorization

I,_____, agree to pay Action Behavior Centers for all services rendered and agree to abide by the following guidelines:

Insurance

I hereby authorize Action Behavior Centers to furnish my insurance carrier any information acquired in the course of intake, evaluation, or treatment necessary to complete my insurance forms, obtain pre-authorization for services, and to submit claims for services covered under my insurance plan. Also, I hereby assign to Action Behavior Centers all payments for services rendered. In the event that my insurance company does not pay for services rendered, I understand that I am fully responsible for all payments due.

Payment

I understand I will receive invoices for services rendered me by Action Behavior Centers not covered by insurance and that Action Behavior Centers will be collecting payment for services and insurance obligations such as amounts sufficient to cover co-pay and co-insurance requirements. Cash, check, debit or credit will be accepted for all payments due on the date indicated on the invoice.

Prompt Payment

We welcome patients who are not covered by insurance plans/payers with whom we are contracted. These patients are out-of-network. We believe our fee schedule reflects a usual and customary fee for the behavioral services provided. We do however offer a discount for prompt payment. This is only available to patients paying in full before their treatment is rendered (or in a timely manner after treatment is rendered). By participating you will not be balanced billed for additional fees, and we offer a discount for this timely payment.

Nonpayment

If my account is over 10 days past due, I will receive a letter stating that I have 10 days to pay my account in full. Partial payments will not be accepted unless otherwise negotiated.

Returned checks or Insufficient Funds

I understand I will be charged a fee of $35 for any returned checks.

Missed appointments

I have reviewed the Running Late or Late Pickup, Cancellations, and Sick
Policy sections of the Action Client Manual and agree to abide by the policies described therein.

I have read and understand the payment policy:

_____ _____

Signature of Client or Guardian Date

Client Responsibility Credit Card Form

The information requested below will be applied to one of the following scenarios:

1) In-network copays, deductibles, and coinsurance fees according to client's insurance plan
2) Out-of-Network Prompt Payment fees to be agreed to between client and Action Behavior Centers Insurance Billing team

Child's Full Name:		
Cardholder's Full Name on Card:		
Billing Address:		
City:	State:	Zip:
Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover		
Name on Card:		
Credit Card Number:		
Expiration Date:	Security Code:	

I authorize Action Behavior Centers to bill my client responsibilities to this credit card in accordance with my specific insurance plan. All charges will be discussed directly with the card owner before fees are processed. No other charges will be processed on my credit card unless I specifically request Action Behaviors to do so in writing.

Signature:_____Date: _____

Financial Hardship Policy

Action Behavior Centers LLC (the "Practice") offers this Financial Hardship Policy pursuant to which clients of the Practice may be eligible to receive a reduction of their client financial responsibility based solely upon their financial condition and their ability to pay. This policy was enacted for those clients that truly cannot afford to pay for services due to financial hardship.

Federal Law has consistently provided an important exception to the general prohibition against waiving cost- sharing amounts, such as coinsurance and deductibles, in situations of financial hardship.

Specifically, under federal fraud and abuse laws, generally permit such cost-sharing amounts may be waived as long as:

i. the waiver is not offered as part of any advertisement or solicitation;
ii. the party offering the waiver does not routinely waive cost-sharing amounts; and
iii. the party waives the cost-sharing amounts after determining in good faith that the beneficiary is in financial need or reasonable collection efforts have failed. Section 1128A(i)(6)(A) of the Act, 42 U.S.C §1320a-7a(i)(6)(A).

This Financial Hardship Policy has been specifically reviewed and updated in accordance with these federal regulations and believed to be fully in compliance with Section 1128A(a)(5) of the Social Security Act (the "Act"), or under the exclusion authority of Section 1128(b)(7) of the Act, or the civil monetary penalty provision at section 1128(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, and the federal Anti-Kickback Statute.

It is the Financial Hardship Policy of the Practice to collect all applicable co-pays, deductibles, coinsurance or other amounts owed by a client (or his/her legal representative). A client is legally responsible for all charges regardless of any applicable insurance coverage or third-party payment or reimbursement without regard to the insured, uninsured or under-insured status of the client. A client's obligation to pay his/her co-pay, coinsurance and/or deductible shall only be waived or reduced as permitted by this Policy, federal and state law and/or payer contractual provision.

This Financial Hardship Policy shall be the authority governing all of the Practice's financial practices for all types of claims and health programs. Any statement by an employee of Action Behavior Centers LLC that is inconsistent with this Policy is invalid and should not be relied upon by the patient or patient's parent/caregiver/legal representative.

This Financial Hardship Policy is communicated to every employee of the Practice, and is available for inspection and reference at our practice's administrative office for compliance and inspection purposes.

This Financial Hardship Policy is disclosed to all prospective clients and signed by the clients prior to services being rendered. Each client's eligibility under this policy is determined on individual, client-by-client basis solely based on each individual's financial and medical needs in accordance with all governing federal and state laws.

The Financial Assistance Policy shall be applied uniformly to all clients regardless of the type of insurance they possess, whether or not they are uninsured, and regardless of their race, religion, age, disability, gender, or sexual preference.

Our financial hardship policy is intended to establish criteria to determine the appropriateness of waiving or lowering co-pays, co-insurance, and/or deductible amounts or other amounts owed to the Practice and to assure that any such waivers or reduced payments that may occur are consist with applicable law. The Practice will not waive or discount out-of-pocket amounts, and/or deductibles and/or coinsurance other than in accordance with this policy. Financial hardship discounts shall be applied to a patient balance after all third-party payments or discounts have been applied to our professional fees.

A patient qualifies for our financial hardship policy based upon the size (number of individuals) living in the household and their income.

Household income for the most recent tax period can be determined based the provision of third party documentation, which may include but is not limited to: IRS form W-2, individual tax returns, three (3) most recent employer paystubs, bank statements for the last three (3) months, receipt of unemployment benefits, social security and/or pension retirement award letter.

Number of individuals living in the household should be counted by including primary tax filer, his/her spouse (if any) and any dependents.

To determine if you may qualify, please answer the two questions immediately below:

Number of individuals living in your household:	
Household income for most recent tax period:	

Then, to determine if you are eligible for a Financial Hardship Discount, use the below chart:

1. Find the correct number of individuals living in your household on the far-left column.
2. On that row, find the first number you see to the right that exceeds your household income.
3. Go to the top of that column to find the associated Financial Hardship Discount.

Financial Hardship Discount Chart

Size of Household	2020 FPL	100% Discount	95% Discount	75% Discount	50% Discount	25% Discount	0% Discount
1	$12,760	$38,280	$44,660	$51,040	$57,420	$63,800	$70,180
2	$17,240	$51,720	$60,340	$68,960	$77,580	$86,200	$94,820
3	$21,720	$65,160	$76,020	$86,880	$97,740	$108,600	$119,460
4	$26,200	$78,600	$91,700	$104,800	$117,900	$131,000	$144,100
5	$30,680	$92,040	$107,380	$122,720	$138,060	$153,400	$168,740
6	$35,160	$105,480	$123,060	$140,640	$158,220	$175,800	$193.380
7	$39,640	$118,920	$138,740	$158,560	$178,380	$198,200	$218,020
8+	$44,120	$132,360	$154,420	$176,480	$198,540	$220,600	$242,660

For families/households with more than 8 persons, add $4,480 for each additional person.
This table shall be adjusted in accordance with annually released changes to the Federal Poverty Guidelines.

Based on this chart, our family qualifies for_____% discount.

Please note that you will be asked to bring copies of the substantiating documentation used by you to determine your available discount to the Practice for review and verification. A member of Action Behavior Centers finance team will review your information and document verification of same in your financial file.

If you qualify under this Policy, updated information will be requested by Action Behavior Centers not less frequently than annually and adjustments will be made as appropriate.

I. Extraordinary Situations

For clients that have experienced recent hardship that impact their income and ability to pay for services, charity care discounts shall be considered at the sole discretion of the Practice's Charity Care Committee. These circumstances may include, but are not limited to, recent:

- □ Loss of employment
- □ Death in family
- □ Physical disability
- □ Mental illness
- □ Recent financial hardship

ALL CLIENTS WILL BE REQUIRED TO CERTIFY TO THEIR ADJUSTED GROSS INCOME AS STATED ON THEIR MOST RECENT FEDERAL INCOME TAX RETURN FOR THE MOST RECENT TAX PERIOD TO EARN CHARITY CARE DISCOUNTS. CHARITY CARE DISCOUNTS SHALL BE APPLIED TO THAT PORTION OF CLIENT RESPONSIBILITY SUCH AS DEDUCTIBLES, COINSURANCE OR OTHER NON-COVERED SERVICES ONLY. CLIENTS SHALL NOT RECEIVE ANY DISCOUNTS ON AMOUNTS PAID BY HEALTH INSURANCE COMPANIES OF THE CLIENTS OR ON INSURANCE CHECKS TURNED OVER TO ACTION BEHAVIOR CENTERS LLC BY THE CLIENT.

II. Conditions on Discounts and Waivers

Discounts and waivers provided under this policy are conditioned upon the continued cooperation of the client and/or guarantor in (i) the provision of substantiating document of financial need; and (ii) the Provider's pursuit of fair reimbursement from the insurer or payor of benefits. Failure to cooperate may result in forfeiture of discounts and waivers provided under this policy.

Signed to and Agreed to by: _____

Patient and/or Guarantor

Date: _____

Balance Bill Policy for Out-of-Network Claims Only

We are an out-of-network healthcare provider with some health plans. This means that we are not a contracted provider with some health plans.

In many instances, the health plans with which we are a not a contracted provider do not pay our charges for medical services in full. We recognize that, as a result, we have an obligation to bill our out-of-network patients the difference between our charges and all payments received. This is commonly referred to as a "Balance Bill". The Balance Bill amount owed by the patient in some cases is not properly stated on the health plan's EOBs and remittances. We do not balance bill patients until all medical claims are billed to your health plan and we take all necessary steps to ensure that your claims are paid at rates set forth in your health plan, which, in many cases, includes our filing appeals with your health plan on your behalf.

We have created this Balance Bill Policy to comply with state and federal laws that require the balance billing of clients for out-of-network claims. This Policy applies to all of our facilities that you may encounter during your complete course of treatment. Once we feel confident that no further payment will be made by the health plan, we will balance bill the patient the difference between our charge and all payments received. We recognize that not all of our patients will be able to afford their patient responsibility for the balance bill, their deductibles, copayments and coinsurance. As a result, we have created a financial hardship policy pursuant to which we may reduce and, in some cases, waive your patient responsibility. Please review our Financial Hardship Policy and let our staff know if you have any questions.

Thank you for being our patient.

Agreed to by /Printed Name:	
Signature:	
Date:	

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF ALL RIGHTS TO PURSUE ERISA OR OTHER LEGAL AN ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations (including all Fiduciary rights) without any limitations that I and my dependents have under my health plan to the Provider (Action Behavior Centers LLC) and the Provider's representatives ("My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- □ File medical claims with the health plan
- □ File appeals and grievances with the health plan and other applicable state review processes
- □ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan for purposes of seeking payment for services rendered
- □ Bring legal action to assert any payments due under my health insurance or health benefit plan
- □ Assert non-benefit claims including the right to request information and pursue civil penalties
- □ Assert claims for a breach of fiduciary duty

I intend that the Provider have full derivative rights, fiduciary rights, and all applicable health insurance benefits and rights without limitation. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including but not limited to co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to:

- □ Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments;
- □ Process insurance claims generated in the course of examination or treatment; and allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (i) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (ii) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, non-benefit claims, or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I authorize communication with the Provider and its authorized representatives by email and my email address is

_____@_____.

I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Client or Guardian:	Date:

PATIENT AUTHORIZATION TO OBTAIN SUMMARY PLAN DESCRIPTION & 5500 FORM

I hereby direct you to forward to Action Behavior Centers LLC the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. Summary Plan Description (SPD)
2. 5500 Form (Plan Annual Report)
3. Certified Copy of Certificate for PPACA Grandfathered Plan.

Please forward to the below address immediately:

Action Behavior Centers LLC
2100 Kramer Lane Suite 150
Austin TX 78758
Fax 512-532-6160

Client Name (Print):	
Signature of Guardian:	
Date:	