

How to Sign a Document Electronically in Adobe Acrobat Reader (Desktop, Laptop)

NOTE: Complete the signature last. Saving the file after adding the signature makes it so the other fields are no longer editable.

Step One:

considerate of the rights of other patients and ABM personnel.
ding information about unexpected difficulties you have involving your health care, and
ng it known whether you clearly understand your plan of care and the things you are asked
ng appointments, arriving on time, and paying for appointments missed, rescheduled or
illed less than one business day in advance of the appointment time.
ring your insurance benefits and co-pays, getting pre-approval when necessary, and paying
y balance remaining after insurance adjustment, regardless of our prior estimates of your
y amount.
ding us with correct information about your sources of payments and ability to pay your bill,
aying for charges not covered by insurance.

nt Consent:

ing below, I agree to accept services from Advanced Behavioral Medicine, PC. I received a
the HIPAA Privacy Notice. I agree that my confidential information may be released to my
ce carrier, my doctor, and to others, as described in the HIPAA Privacy notice.

**to keep all scheduled appointments or provide advance notice of
lations, whenever possible. I agree to pay a \$50.00 fee for appointments
l, rescheduled or cancelled without 24 hour notice the first time and the full
rate following, regardless of reason. I agree to pay an interest charge of 1.4% per
on any unpaid balance after 30 days.**

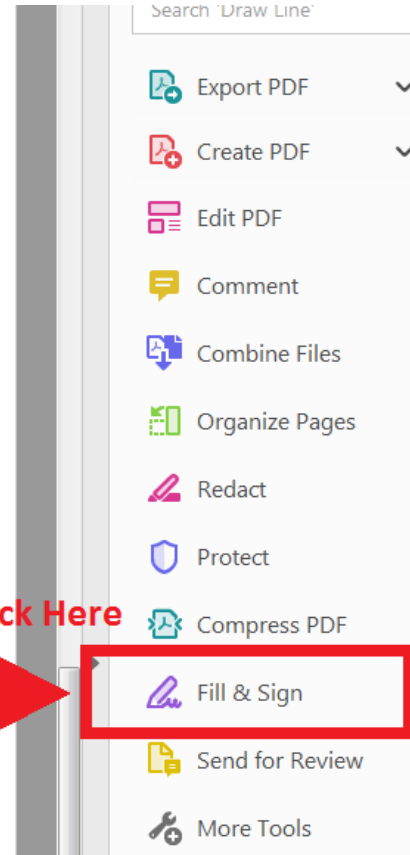
een given and read the information rate sheet and you understand that fees are subject to

stand that ABM policies described above may change over time and if so, the changes will be
in the clinic lobby or distributed to me directly.

or do not agree to allow my ABM to share, for the purpose of
ating care, my evaluation and treatment information with my current physician or other
professional involved in my care, listed below. This permission to share information will
months from today.

Current physician or other medical/mental health provider:

or do not agree to allow ABM to survey me during or after treatment
ie quality of the care I received. I understand that I may ignore the survey or choose not to
ate.



Or Click on More Tools if you do not see Fill & Sign. Search for Fill & Sign then add it and it will appear above.

Step Two:

1. Click Here 

2. Click Here 

Patient Consent:
By signing below, I agree to receive a copy of the HIPAA Privacy Notice from my insurance carrier, my doctor, and the clinic. I understand that my health information may be released to my insurance carrier, my doctor, and the clinic for the purpose of coordinating care, my evaluation and treatment, and for the purpose of sharing my information with my current physician or other health care providers. I agree to pay for my services. I understand that fees are subject to change over time and if so, the changes will be posted in the clinic lobby or distributed to me. I agree to keep all scheduled appointments or provide advance notice of cancellations, whenever possible. I agree to pay a \$50.00 fee for appointments missed, rescheduled or cancelled without notice the first time and the full clinic rate following, regardless of reason, if I fail to pay an interest charge of 1.4% per month on any unpaid balance after 30 days. I have been given and read the information change. I understand that ABM policies described in the clinic lobby or distributed to me. I agree or do not agree to share, for the purpose of coordinating care, my evaluation and treatment, and for the purpose of sharing my information with my current physician or other health care providers.


Note: After your signature is created it will be accessible here if needed multiple times and with any document.

Tip: If you need to place multiple different signatures (ex. Parent/Child) you can delete the existing one by clicking on the minus sign in the same menu above and then start over.

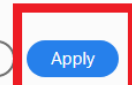
Add Signature 

Add Initials 

Step Three:

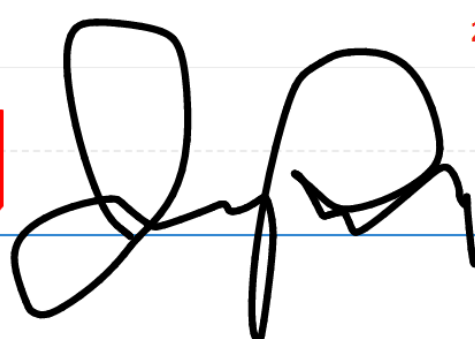
1. Click Here 

2. Draw your signature on the blue line.

3. Click Here 

Save signature **Click here to have access to reusing the same signature across all documents without having to complete this process again.**

Cancel **Apply**

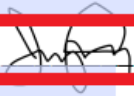


Step Four:

I agree or do not agree to allow ABM to survey me during or after treatment about the quality of the care I received. I understand that I may ignore the survey or choose not to participate.

I have understood and agreed to all the rights and responsibilities described above. I am voluntarily seeking services, including medical assessment and treatment, at Advanced Behavioral Medicine, PC. If I am found to have a medical illness I will be offered usual and customary treatment or be advised to the contrary. I understand that this process begins with an initial assessment and may include recommendations for psychological testing, psychiatric evaluation, prescription medication, individual psychotherapy, family or group psychotherapy, and other prescribed treatments

Patient Name:

Patient Signature: 

Date:

Optional

Email:

For communication use between you, the doctor, clinician staff and office staff of Advanced Behavioral Medicine.

Your cursor will turn into an image of your signature. Click mouse over Patient Signature line and you are done!