



CELLULAR DEVICE OPT-IN CONSENT FORM

By signing this agreement, you specifically request, expressly consent to receive, and authorize Neurobehavioral Consultants, LLC ("the Clinic"), its affiliates, business associates, and service providers to deliver, or cause to be delivered, calls and SMS/text and voice messages to your cell phone, and residential line as applicable, using an **automatic telephone dialing system and/or using an artificial or pre-recorded voice**. This could result in charges to you according to your data plan. These calls and messages will be for health care and other purposes including but not limited to, for the purpose of treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for the purpose of servicing your account, payment and billing and collecting any amounts you may owe.

If at any point you change or obtain a new cell phone number, or if you no longer maintain the phone number you originally provided to us, you agree to notify the Clinic immediately of such change by calling us at 317-550-3043 or in writing at the following address: **6296 Rucker Rd Ste A, Indianapolis, IN 46220**. You agree to provide your full name, address, date of birth, and phone number in your notification.

You may be held liable for failure to do so, as outlined in the following provision.

Indemnity Provision - READ CAREFULLY:

You agree to indemnify and hold the Clinic, its officers, agents and employees harmless from any liability, loss or damage, including but not limited to, attorney's fees, they may suffer as a result of claims, demands, costs or judgments against them arising out of alleged violations of the Telephone Consumer Protection Act (TCPA) or similar laws, resulting from autodialed or artificial or pre-recorded voice calls placed to an incorrect or reassigned phone number(s), originally belonging to you or which you provided to the clinic, but of which you failed to timely notify the Clinic that such number(s) was incorrect or no longer assigned assigned to you.



Opt-In

I authorize and expressly consent to receiving calls and/or SMS/text and voice messages delivered to my phone number placed by the Clinic, its affiliates, associates, and service providers, from an automatic telephone dialing system and/or using an artificial or pre-recorded voice, for healthcare and other purposes, including treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for servicing my account, payment and billing, or collecting amount I may owe. I agree to notify the Clinic immediately if I change or obtain a new phone number, or no longer maintain the phone number provided herein, and expressly acknowledge that I may be held liable for failure to do so, as outlined above.

I understand that I need not sign this form as a condition to purchase goods or services and that SMS/text messages and voice messages carry certain risks. For example, messages may be sent in unencrypted form. They could be received by others if others have access to my device or if my messages are sent to another device. I understand the risks, and I expressly consent to receiving these messages and ask the Clinic to communicate with me in this form.

Patient/Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Relationship to Patient: Self Guardian/Parent POAH DPOA Other _____