

**GA BEHAVIORAL HEALTH PROGRAM**  
***Advanced Behavioral Health, Inc.***  
***Access to Web-Based Authorization & Claims Systems***  
**Statement of Rights & Responsibilities**

In order to maintain safe and secure communication that is consistent with all applicable state and federal rules and regulations including those outlined in the Health Insurance Portability & Accountability Act (HIPAA), it is essential that individuals granted access to the ABH secure, web-based authorization and claims systems (Electronic Registration System/ERS, ABH Claims Entry System/ACES) understand and comply with all safeguards. Comprehensive information related to safe and proper use of these secure applications is available in the ERS User Manual and the ACES User Manual. We ask you to review the following statements and to confirm your understanding of the statements contained by signing the bottom of the form.

1. I understand that the login and password assigned to me are intended for my use only and are not to be shared or distributed to others.
2. I agree to maintain the confidentiality of client information while online by logging off the ERS if I leave my computer unattended.
3. I agree to follow the policies and procedures regarding requests for authorization as outlined in the GA Behavioral Health Program Provider Manual.
4. I understand that my employer will receive a list of the employees with current access to ERS, and will be informed of any suspension or termination of my access to ERS.
5. I agree to notify Advanced Behavioral Health, Inc. immediately if my employment status with \_\_\_\_\_ changes. I further understand that my access to ERS is fully conditional to my employment with this agency.
6. I understand that my access to the ABH online system(s) may be suspended or terminated immediately by ABH if there is evidence of inappropriate use or distribution of the system or my login/password.

Provider Agency Name: \_\_\_\_\_

Your Name (please print) \_\_\_\_\_ Phone: \_\_\_\_\_

Your Signature: \_\_\_\_\_

Your Supervisor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisors Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

\*Please note supervisor name and signature required to process.

**I have read and agree to the statements listed above.**