Patient Rights and Responsibilities Form
Caring Hearts Mental Health Services, LLC
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Patients have the right:

1. To be treated humanely, with dignity and respect
2. To not be discriminated against due to race, religion, ethnicity, gender, sexual orientation or disability
3. To receive treatment appropriate to their mental health condition
4. To have diagnosis and treatment explained in understandable terms
5. To participate in the formulation and revision of their treatment plan
6. To refuse treatment, request another provider or seek a referral outside of this practice
7. To receive services that adhere to the principles of confidentiality and privacy except in the following, special circumstances:
    a. When circumstances place the patient's welfare or that of others in immediate danger
    b. When disclosures made by the patient raises the suspicion of child physical, mental or sexual abuse or neglect or if an adult discloses an allegation of abuse in their childhood. In this situation, the law requires a report be made to the appropriate agency; usually Social Services
    c. When a court order requires testimony or release of a patient's records
    d. In a circumstance where the provider determines that the consultation within the practice is needed in order to provide optimal treatment, in which case the utmost discretion will be used to insure privacy.
8. To access your medical record as deemed appropriate by the provider

Patients have the responsibility:

1. To know the benefits and exclusions of their insurance coverage and to provide us with current insurance information
2. To make regular and prompt payments for services rendered
3. To keep scheduled appointments. Patients will be charged for missed appointments or cancellations for this 24 hour notice has not been given.
4. To follow the mutually agreed upon treatment
5. To be open and honest in sessions with your provider
6. To report and safety concerns or abuse allegations to your provider
7. To discuss with your provider any concerns about treatment, including the desire to terminate treatment

Patient Signature_____ **Patient Name**_____**Date**_____

Provider Signature _____ **Provider Name**_____**Date**_____