CLIENT NAME		TODAY'S DATE		
STREET	CITY	ST	ZIP	PHONE
EMAIL ADDRESS		DATE OF BIRTH		
THERAPIST				

NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES

We recognize that information about you and the services you receive is personal and we value the importance of protecting your privacy. The following provides you a brief description of our privacy practices. While we reserve the right to update these practices, you may request an updated copy of our practices by contacting our business manager at any time.

Use of Information

As we provide services to you or your family member, we may use your information for the following purposes:

- **Treatment of Services:** The specialists who work with you will maintain information about you and the services they are providing to you in order to more effectively meet your needs, which may include consulting with another specialist within the organization who can provide insight into your care, or another specialist outside the organization who is involved in your care. We may also use the information to refer you to others who may be able to help you or to tell you about other services or products that may be helpful. We may also communicate with family members or others involved in your care or payment for your services when appropriate, and we may utilize information to remind you of appointments or services.
- **Billing:** We utilize basic information for billing purposes according to industry standards and requirements and state and federal law. This may include providing basic information regarding your treatment to your insurance or a third party to bill for services or to authorize services before they are provided.
- **Healthcare Operations**: We use information regarding treatment and services to evaluate and improve the quality and efficiency of the services we provide, to improve customer service, and to train staff who assist in your care.

On occasion we may obtain assistance from a third party to help with your care or for business operations. If we utilize any third party to assist in your care or our business operations (such as billing), they are also required by law to follow the same privacy requirements that we do.

Privacy Limitations

There are a limited number of situations in which we are authorized and/or required to provide your information without written consent. These include the following:

- Situations where you or another person appears to be at risk of harm, including but not limited to abuse or neglect;
- When required by a court of law with appropriate jurisdiction, in legal proceedings or other similar situations, and to law enforcement where authorized by the law or a court order;
- In situations involving the public health, where required by law, including reporting communicable disease, reactions to medication, work-related illness (including reporting related to workers' compensation) and to prevent serious public health threats;
- Industry audits or inspections by entities responsible for monitoring the services we provide;
- For government use for intelligence or national security or when otherwise required by law.

Rights

The following are some important rights you have and should be aware of. You or your legal representative has the right to:

- Ask general questions about the organization and its functions. Although some functions may be proprietary or confidential, wherever possible we will try to answer these questions fully.
- Participate in your treatment and the formulation of your treatment goals.

- Request a change of the specialist that is providing services to you by contacting the clinic business manager or the clinic director. Where possible we will try to accommodate these requests. If you we are not able to accommodate the request we will attempt to resolve concerns you have about the services you receive.
- Know about and explore different methods of treatment
- Request special restrictions or sharing your information. Wherever possible, we will accommodate these additional restrictions.
- Request to review and copy your information, including treatment information. In some cases we will not be able to provide all information requested depending upon the circumstances and legal requirements. Wherever possible, we will assist with this. A fee may be applied in such situations.
- Request additions or corrections to your information where appropriate.
- Request that we utilize a specific contact number for you.
- Request an accounting regarding disclosure of your information. There are some restrictions on this, including routine healthcare, billing, and healthcare operations.
- Request changes in your services.
- Receive care regardless of race, religion, disability, gender, sexual orientation, ethnicity, or national origin.
- Be treated with respect.
- Withdrawal from services (except where required by law and under court jurisdiction). *If you are a minor and have a legal guardian, this will require your legal guardian's authorization. If you receive other services from Summit Community Counseling, withdrawal from some services may affect your ability to participate in or receive other related services.*

Responsibilities

The following are some important responsibilities that you have in receiving services. You have the responsibility to:

- Provide complete and accurate information regarding your history and other information related to treatment and services.
- Be respectful to others and their property.
- Follow the rules associated with the services you receive.
- Cooperate fully with the services being provided and follow-through with assignments.
- Attend scheduled appointments and meetings. When attendance at such is impossible, arrange for another appointment immediately and at least 24-hours in advance. **When 24-hour advance notice is not possible, a missed or late-cancel fee** will be charged according to Summit's current policy.
- Make co-pays and other payments for services at the time of service. If services are paid by another source, stay informed of your insurance or other benefits and ensure that payment is made promptly.

There may be additional restrictions and requirements on the use and sharing of your information, or other obligations regarding the services you receive. It is our intent to provide you with the best information we can and to protect your information to the greatest degree possible. If you have questions about these requirements or your rights, whether listed or not, please do not hesitate to discuss these with the specialist providing your services, or contact the clinic business manager or clinical director.

By signing below, I am hereby acknowledging that I have read and understand my Rights and Responsibilities, and have deferred any questions or concerns to the clinic business manager.

NAME (PLEASE PRINT)	
CLIENT SIGNATURE (if over 18)	DATE:
PARENT/GUARDIAN SIGNATURE (if applicable)	DATE:
WITNESS SIGNATURE (office use only)	DATE: