Renee B. Gusman, LPC • Phone 504-813-0951 • Fax 504-486-7595

PATIENT'S BILL OF RIGHTS

Patient's Rights and Responsibilities for Informed Consent to Treatment

Patients Name: ____

PATIENT'S RIGHTS:

a. The rights to privacy, security, and respect of property.
b. The right to voice a complaint/concern regarding care or service.
c. The right to participate in all aspects of care/services.
d. The right to refuse all or parts of his/her care, to the extent permitted by law, including the right of informed consent or refusal of service delivery.
e. The right to be informed that consistent refusal or lack of participation in prescribed services may result in termination from therapy. However, a referral to another therapist will be provided.
f. The right to be informed of the value or purpose of any service that will be performed, including the benefits, risk, and who will perform the service.
g. The right to review their records.
h. The right to 24 hour crisis intervention: 504-568-3130. 800-273-TALK (8255) 24 hour hotline. 800-799-4889 (TTY). 888-623-9454 (Spanish)
i. The right for protection from abuse, neglect, retaliation, humiliation, exploitation.

PATIENT'S RESPONSIBILITIES:

a. The patient shall attend individual sessions as scheduled.
b. The patient shall provide payment for services received as agreed upon.
c. The patient and/or guardian shall attend sessions once a week or as discussed with therapist.
d. The legal guardian of all minors under the age of 18 shall participate in treatment, as prescribed.
e. The patient and/or guardian shall sign and participate in developing the patient's treatment plan initially and every six months thereafter.
f. The patient shall notify therapist if moving (change of address), hospitalized (for any reason), incarcerated or leaving the local area for an extended period of time.
g. The patient shall notify therapist of any insurance changes prior to the next scheduled session to avoid a gap in services.

I have received a copy of my rights and responsibilities and consent to have Renee Gusman, LPC be my mental health provider. I agree to participate in my treatment to the best of my ability. I understand that consistent refusal of prescribed services may result in discharge and referral to another therapist.

X ______________________________ __________ X ______________________________ _________

Signature of Patient or Guardian Date Renee Gusman, LPC Date