



Credence Therapy Associates
1 ½ West Geneva Street
Elkhorn, WI 53121
(262)723-3424

RIGHTS AND RESPONSIBILITIES

Name of patient _____ Age of patient as of today's date _____

Please read the following statements and provide your initials or signature where indicated agreeing that you did review this and understand its contents. If you have any questions, please ask your therapist or any of the office staff to assist you. You will also be given a copy of this document upon request

If the patient is age 18 or over, patient initials/signatures only;

If the patient is age 13 to 17, patient and parent initials/signatures;*

If patient is age 12 or under, parent initials/signatures only.*

**For purposes of this document parent shall mean parent or other legal guardian*

GENERAL NATURE AND PURPOSE OF OUR PROGRAM

- Our goal is to provide confidential, professional treatment services specialized to meet the needs of the individual client. We will work with each client to formulate the most comprehensive yet concise treatment plan. We do not discriminate on the basis of age, gender or creed. We accomplish our goals through individual, couple, family and group therapy.

Patient Initials _____ Parent Initials _____

PATIENT BILL OF RIGHTS

When I/my child receive(s) services for mental health, alcoholism, drug use, or a developmental disability, as an outpatient client, I have the following rights under the Wisconsin Statute section 56.61.

I. TREATMENT RELATED RIGHTS

- To give informed consent to my treatment.
- To be free from having unreasonable arbitrate decisions made about me.
- To receive prompt and adequate treatment.
- To refuse any treatment.
- To be free from unnecessary or excessive medication.

Patient Initials _____ Parent Initials _____

II. COMMUNICATION AND PRIVACY RIGHTS

- To refuse to be filmed or taped without prior written consent.
- To have my treatment records and conversations about my treatment kept confidential (section 51.30, Statute)

COMMUNICATION AND PRIVACY RIGHTS (continued)

- To have access to my treatment record after discharge (or during treatment if the facility director approves it) and to have access at all times to records of medications I take or any treatment I receive for physical health reasons.

Patient Initials _____ *Parent Initials* _____

III. RIGHTS OF ACCESS TO COURTS

- To bring a legal action for damages against those who violate my rights.

Patient Initials _____ *Parent Initials* _____

IV. YOUR RIGHT TO FILE A COMPLAINT/GRIEVANCE PROCEDURE

- If I feel that my rights have been violated, I have the right to a grievance procedure. Credence Therapy Associates has a grievance process through which I may file a complaint. Grievances must be filed in writing within 45 days of the incident or issue. The staff will supply me with a copy of the Grievance Procedure upon request. I may, at the end of the grievance process, or at any time during it, choose to take the matter to court.

Patient Initials _____ *Parent Initials* _____

V. EXCEPTIONS TO CONFIDENTIALITY *I understand that an exception may be made to my right to confidentiality in case of:*

- An indication of threat to myself or others
- An Indication of Child abuse/Neglect
- A valid request by any Court system with jurisdiction

Patient Initials _____ *Parent Initials* _____

VI. PATIENT RESPONSIBILITIES *I understand that it is my responsibility to:*

- To obtain any necessary referrals or pre-authorizations as may be required by my insurance plan for services at Credence Therapy Associates.
- To provide ongoing information about the following: past and present illnesses, hospitalizations, medications, changes in medical conditions, and medications, management of pain, and other health-related matters to the best of my ability.
- To provide accurate and complete information for my assessment and treatment.
- To cooperate with all Credence Therapy Associates personnel caring for me and to ask questions about directions I do not understand.
- To inform Credence Therapy Associates Staff about family members or other professionals that may wish to be involved in my care and to provide staff with written consent to coordinate care with them.
- To participate in the decision making process regarding my treatment and understand the purpose and probable benefits and risks of my treatment.
- To keep appointments or to telephone 24 hours in advance when unable to keep an appointment.

PATIENT RESPONSIBILITIES (continued)

- To inform Credence Therapy Associates of address, telephone number, insurance, and other status changes within 30 days or prior to my next visit whichever comes first.
- To be prompt in payment of Credence Therapy Associates bills, to provide the information necessary for insurance processing and to be prompt about asking questions concerning my bills.
- To be respectful of others and other patients' confidentiality.
- To avoid jeopardizing the safety and security of staff and other patients.

For the protection of all our patients, employees, and visitors, failure to comply with these responsibilities due to mental health symptoms may result in discharge from treatment.

Patient Initials _____ Parent Initials _____

AFTER BUSINESS HOUR THERAPIST AVAILABILITY

Credence Therapy Associates provides me with after hour access to a therapist in case of critical but non-life-threatening events. In the event of a life threatening emergency, I am to dial 9-1-1. To access an after hour therapist, I can dial (262) 325-7879. This number is also available on Credence Therapy Associates answering machine.

Patient Initials _____ Parent Initials _____

IF THE PATIENT IS A MINOR

For legal and clinical reasons, all minors must be accompanied by a natural or legal parent, or by a legal guardian. This is required at the first appointment and there are no exceptions to this. On an ongoing basis, it is required as requested by the therapist. The parent is required to complete and initial/sign all patient paperwork. The parent filling out the form for the child/adolescent must claim responsibility for all charges incurred.

Patient Initials _____ N/A _____ Parent Initials _____

I have read and understand the information provided in this Rights and Responsibilities document. If requested, have a received a copy of this document.

Patient Signature (Age 13+):

Signature

Date

*Parental/Guardian Signature
(for clients under age 18):*

Signature

Date

Witness Signature:

Signature

Date