Client Bill of Rights

- I have chosen to receive treatment services and understand I may terminate therapy at any time unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and me, I will work with my therapist to resolve my difficulties.
- I understand that we may discuss material during my treatment that will be upsetting in nature, which may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released following federal and state laws regarding such documents and information confidentiality.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there is a danger to oneself or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that my therapist may contact my health plan to ensure continuity and quality of my treatment and, after completing treatment, to assess the outcome of treatment.
- I have read and had explained to me the Basic Rights of Individuals, including:
    - The right to be informed of the various steps and activities involved in receiving services.
    - The right to share in forming the plan of care/treatment plan.
    - The right to confidentiality under federal and state laws relating to the receipt of services.
    - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
    - The right to make an informed decision whether to accept or refuse treatment.
    - The right to contact and consult with counsel at my expense.
    - The right to select practitioners of my choice at my cost.

I understand that my therapist and health plan representatives may exchange all information about my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and utilization review purposes. I understand that I can revoke my consent at any time except after treatment has already been rendered, and action has been taken in relying on this consent. If I do not withdraw this consent, it will expire automatically one year after all treatment claims are paid as provided in the benefit plan.

I have read and understand the above:

_____	_____
Print Name	Date of Birth
_____	_____
Signature of Identified Client/Parent/Legal Guardian	Relationship
_____	_____
Witness	Date