CLIENT RIGHTS / GRIEVANCE

I understand my basic rights as a client. These rights include:

1. The right to impartial access to treatment services regardless of race, religion, ethnic background, physical handicap or source ofA financial support.

2. The right to have personal dignity recognized and respected in all aspects of interaction and contact with facility staff.

3. The right to individualized treatment, including participation in the development of a Treatment plan and implementation of the plan in cooperation with professional staff.

4. The right to confidentially of communication with treatment staff and of material included in the treatment record; federal confidentially rules (42 CFR part 2) prohibits the release of any information about a client's participation in this program to anyone outside of this agency without a client's written authorization for the disclosures of my protected health information.

5. The right to privacy of health information, under H.I.P.A.A., (Health Insurance Portability and Accountability Act). Rules accept where federal or state rules are more restrictive H.I.P.A.A. Notice of Privacy Practice is given to all clients extensively explaining the rules and exceptions to confidentiality in special cases of imminent emergency or court order.

6. The right to express opinions and discuss the plan and course of treatment with persons responsible, and to receive a stated grievance in accordance with established policy.

7. The right to be informed in any rules or exceptions, which apply to the client's conduct and participation in treatment.

8. The right to a satisfactory explanation of treatment services and this statement of rights before giving consent to treatment.

9. The right to notify the staff of discontinuance of treatment at any time without being financially responsible for any planned treatment services that was not provided.

10. The right to be informed of alternative treatment resources other than those provided by In The Garden Counseling.

11. The right to access their record in compliance with state and federal laws; to inspect and obtain a copy of your treatment or individual treatment plan and other health information maintained by the agency. This process includes submitting a request in writing to the office manager or the appropriate clinician.

I understand that if I have a complaint/grievance, I should: Submit Concerns/Grievances in writing to In The Garden Counseling Attn: Johannah Robinette. Concerns will be responded to within 3 business days. If unresolved, I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance: North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services www.ncdhhs.gov/mhddsas Advocacy and Customer Service Section:
919-715-3197
DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)
Disability Rights NC www.disabilityrightsnc.org 2626 Glenwood Avenue, Suite 550, Raleigh, NC, 27608 (877) 235-4210 or (919) 856-2195 Email: info@disabilityrightsnc.org

Cancellation and Missed Appointments
We reserve your appointment slot for you. If you are unable to make your scheduled appointment, please cancel prior to **24 hours** of your appointment time. Appointments canceled within **24 hours** will be considered a late cancellation. Two late cancellations or no-show appointments will result in a referral to another provider for services.

Consent for Treatment
By your signature below, you are indicating (1) that you voluntarily agree to receive mental health assessment and mental health treatment and that you authorize me to provide such assessment and treatment as I consider necessary and advisable; (2) that you understand and agree that you will participate in the planning of your care and treatment, that you may stop such treatment at any time; and
(3) that you have read and understood this statement and you have sufficient opportunity to ask questions about and seek clarification of anything unclear to you; (4) that you consent to your clinician to seek emergency medical treatment from a hospital or physician; and (5) that I provided you with a copy of this statement as requested.

By my signature, I acknowledge that I have read and understand this therapist disclosure statement. I consent to therapy with In The Garden Counseling according to the terms described here. I have read the preceding information and understand my rights as a client. Your signature below indicates your permission for us to release the necessary information to your insurance company to access your benefits.

Client's Signature:_____ **Date:**_____

Johannah Robinette
Licensed Professional
Counselor, MAEdS, LPC, NCC