Mindful Balance Psychiatry

Acknowledgment Form

Patient's Right:

I understand my following rights: the right to be treated with dignity and respect, the right of fair treatment regardless of race, religion, gender, sexual orientation, ethnicity, age, disability, or source of payment, the right to have treatment or other information kept private except where required by law, the right to information from staff/providers, in a language I can understand, the right to have an easy to understand explanation of my condition and treatment, the right to know about my treatment choices, the right to information about providers, the right to know the clinical guidelines used to manage my care, the right to know about the complaint, grievance and appeal the process, and the right to share in the formation of my plan or care.

Patient's/parent's/guardian's Signature _____ *Date* _____

Patient's Responsibility:

I understand my following responsibilities: responsibility to give this provider information needed for the best possible care, the responsibility to let this provider know when the treatment plan no longer works for me, the responsibility to follow my medication plan and tell this provider about medication changes, including medications given to me by other providers, the responsibility to treat those giving me care with dignity and respect. The responsibility to keep my appointments, the responsibility to ask my provider questions about my care, the responsibility to let my provider know about the problems with paying fees, and the responsibility to follow the plans and instructions for my care.

Patient's/parent's/guardian's Signature _____ *Date* _____

Arriving Late for Appointment:

Our providers will do their best to be punctual for your appointment unless they have an emergency call. We ask that you be punctual as well. If you are late, for any reason you will receive only the remainder of your scheduled time. This is necessary so we can see following patients at their scheduled time.

Patient's/parent's/guardian's Signature _____ *Date* _____

Consent of Treatment:

I hereby give my consent to be evaluated, diagnosed and treated by this provider, _____

Patient's/parent's/guardian's Signature _____ *Date* _____

HIPAA Privacy Practice Acknowledgement:

I have reviewed the Privacy Practices and I have been provided an opportunity to a copy for my records.

NAME _____ *BIRTHDATE* _____

SIGNATURE _____ *DATE* _____

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