AUSBORN BEHAVIORAL CARE, PC
Client Rights Form

1. I understand that I have the right to decide not to enter therapy (although depending on my situation, there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with who I can continue. **Initials** _______

2. I understand that I have the right to a safe environment during therapy, free from physical, sexual and emotional abuse. Initials _______

3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress. **Initials** _______

4. I understand that I have the right to information about the professional capabilities and limitations of any clinician(s) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. **Initials** _______

5. I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment. **Initials** _______

6. I understand that my confidentiality will be protected and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies and the types of information which must be disclosed. **Initials** _______

7. I understand that I have the right to know if my therapist will discuss my case with supervision or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. **Initials** _______

8. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. Initials _______

9. I understand that I have the right to request the release of my clinical information to any agency or person I choose. **Initials** _______

Client/Guardian Name: ______________________ **Signature:** ____________________ **Date:** ___/___/____

Therapist Name: ___________________________ **Signature:** ____________________ **Date:** ___/___/____