April Norrod, LPC-MHSP
Licensed Professional Counselor
441 East Broad St. Suite P
Cookeville, TN 38501

Client Rights

Client____

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with April Norrod, LPC-MHSP. Further, I consent to have treatment provided by a counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. It is encouraged that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Rights and Responsibilities

You have the right to:

To be treated with consideration, respect, and full recognition of your dignity and individuality regardless of you state of mind or condition.

To be provided treatment without regard to race, color, birthplace, language, gender, age, religion or disability.

To complete privacy of your medical and financial information.

To be informed of treatment options and/or alternative treatment methods regardless of cost or benefit coverage.

To be informed of the risks, benefits, consequences of treatment or non-treatment.

To participate in the development of your individual treatment plan.

To participate in all decision-making regarding your behavioral health care, including discharge of aftercare planning.

To be provided quality treatment by competent staff members.

To refuse to participate partially or fully in treatment of therapeutic activities (unless participation is ordered by the court.)

To be provided treatment in the least restrictive setting that is clinically appropriate, feasible and available.

To be provided with a copy of your basic rights and responsibilities and to have all questions answered to your treatment.

To voice complaints about your services. You can continue to receive services without fear of receiving inadequate treatment.

To be given information about the Declaration of Mental Health Treatment, or to designate a person to make decisions using a durable power of attorney for health care.

To make a recommendations about your rights and responsibilities.

To be provided with a list of available advocacy services and contact information when requested.

To ask for and receive information about your medical records, review the records, make corrections to your medical record and to receive copies of your records.

You Are Responsible:

To provide accurate information to your provider.

To treat health care providers with respect and dignity.

To cancel appointments you are unable to keep.

To follow the instructions and guidance given by providers.

To participate, to the degree possible, in understanding your behavioral health problems and to develop mutually agree upon treatment goals.

I have read the Rights and Responsibilities and all my questions have been answered to my satisfaction.

____ __________

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

____ ______________

Witness Date