CLIENT'S BILL OF RIGHTS

I have chosen to receive treatment at Family Enrichment Center. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist, and myself I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that confidentiality of records or information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I have read and had explained to me the basis rights of individuals who undergo treatment at Family Enrichment Center. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. Right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice and at my expense.

I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance company's representative, if such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

____________________________________ ______________________
Client Signature Date

____________________________________ ______________________
Witness Signature Date

Client Name: ______________________________ Client ID #: ________________________