



59 Murray Guard Drive, Jackson, TN 38305 | 731-394-4109 | www.re-envisioncounseling.com

## Client Information

Today's Date: \_\_\_\_\_

Full Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

Gender/ Preferred Pronouns \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Are you a Student: Yes / No

School \_\_\_\_\_

Grade \_\_\_\_\_

Area of Study \_\_\_\_\_

Relationship Status    Single / Engaged / Married / Widowed / Separated / Divorced / Remarried

Partner's Name \_\_\_\_\_

Partner's Occupation \_\_\_\_\_

List members of your family and/ or all others:

Name	Gender	Age	Living with you?	Relationship to you

## Emergency Contact

Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

## Contact Information

I wish to be contacted in the following manner: (list all the apply)

**Cell Phone:** \_\_\_\_\_

- Leave a voicemail with detailed information
- Leave a voicemail with a call back number only
- Text with detailed information

**Email:** \_\_\_\_\_

- Email detailed information

**Work Phone:** \_\_\_\_\_

- OK to leave a voicemail with detailed information
- Leave a voicemail with a call back number only

**Other:** \_\_\_\_\_

- OK to leave detailed information
- Leave a voicemail with a call back number only

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If the client is under 18 years of age, or if the parent (s) will be responsible for payment, complete this section:

**Parents' Marital Status**            Single / Engaged / Married / Widowed / Separated / Divorced

**Mother's Name** \_\_\_\_\_ **Primary Phone** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Voicemail** Yes / No      **Text** Yes / No

**Address** \_\_\_\_\_ **City, State, ZIP** \_\_\_\_\_

**Employment** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Primary Phone** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Voicemail** Yes / No      **Text** Yes / No

**Address** \_\_\_\_\_ **City, State, ZIP** \_\_\_\_\_

**Employment** \_\_\_\_\_

**If divorced, have parents remarried?**            Father: Yes / No            Mother: Yes / No

**Name of custodial/ primary residential party** \_\_\_\_\_

If there are step-parents, please provide their names:

**Step-Mother** \_\_\_\_\_ **Step-Father** \_\_\_\_\_

## Health Information

Please describe your reason(s) for seeking therapy services:

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How are your concerns affecting your daily life?

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What do you hope improves/ changes as a result of counseling?

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How did you learn about ReEnvision Counseling?

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Have you received counseling/ psychotherapy before? Yes \_\_\_ No \_\_\_

If yes, please give dates and with whom. \_\_\_\_\_

Have you ever been hospitalized for psychological/ psychiatric concerns? Yes \_\_\_ No \_\_\_

If yes, date(s) and reason: \_\_\_\_\_

Have you been through a traumatic experience/ event? Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

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## Current Medication List:

Medication Name	Dose/ Freq	Start Date	Response	Physician

Primary Care Provider \_\_\_\_\_ Clinic \_\_\_\_\_

Psychiatrist Provider \_\_\_\_\_ Clinic \_\_\_\_\_

Other Physicians / Providers \_\_\_\_\_

Please list any major medical illnesses or diagnoses \_\_\_\_\_

\_\_\_\_\_

Please list any medical hospitalizations and dates \_\_\_\_\_

\_\_\_\_\_

Have you ever been arrested or convicted of a crime? Yes \_\_\_ No \_\_\_

If yes, date(s) and reason for arrest(s) or conviction(s): \_\_\_\_\_

\_\_\_\_\_

**Symptom List** (please check all that apply)

- | Past   | Current Only             | Past   |
|--|--------------------------|--|
| <input type="checkbox"/> Anxiety                                 | <input type="checkbox"/> | <input type="checkbox"/> Trauma / Traumatic Event            |
| <input type="checkbox"/> Panic Attacks                           | <input type="checkbox"/> | <input type="checkbox"/> Problems at Work                    |
| <input type="checkbox"/> Social Anxiety                          | <input type="checkbox"/> | <input type="checkbox"/> Problems at School                  |
| <input type="checkbox"/> Obsessive/ Compulsive Behaviors         | <input type="checkbox"/> | <input type="checkbox"/> Problems in Relationships           |
| <input type="checkbox"/> Paranoid Thoughts                       | <input type="checkbox"/> | <input type="checkbox"/> Problems in Parenting               |
| <input type="checkbox"/> Hearing Voices or Other Hallucinations  | <input type="checkbox"/> | <input type="checkbox"/> Financial Concerns                  |
| <input type="checkbox"/> Depression                              | <input type="checkbox"/> | <input type="checkbox"/> Family of Origin Issues             |
| <input type="checkbox"/> Irritable Mood                          | <input type="checkbox"/> | <input type="checkbox"/> Faith Concerns                      |
| <input type="checkbox"/> Excessive Stress                        | <input type="checkbox"/> | <input type="checkbox"/> Chronic Pain                        |
| <input type="checkbox"/> Excessive Fatigue/ Low Energy           | <input type="checkbox"/> | <input type="checkbox"/> Chronic Illness                     |
| <input type="checkbox"/> Difficulty Concentrating                | <input type="checkbox"/> | <input type="checkbox"/> Difficulty Sleeping                 |
| <input type="checkbox"/> Isolating from Others                   | <input type="checkbox"/> | <input type="checkbox"/> Poor Hygiene                        |
| <input type="checkbox"/> Impulsive Behavior                      | <input type="checkbox"/> | <input type="checkbox"/> Alcohol and/or Drug Use             |
| <input type="checkbox"/> Thoughts of Self-Harm or Suicide        | <input type="checkbox"/> | <input type="checkbox"/> Pornography Use                     |
| <input type="checkbox"/> Thoughts of Harming Others              | <input type="checkbox"/> | <input type="checkbox"/> Excessive Video/ Online Gaming      |
| <input type="checkbox"/> Self- Harm Actions or Suicidal Attempts | <input type="checkbox"/> | <input type="checkbox"/> Unwanted Sexual Experience          |
| <input type="checkbox"/> Harming or Injuring Others              | <input type="checkbox"/> | <input type="checkbox"/> Patterns of Disordered Eating       |
|  |                          | <input type="checkbox"/> Recent Death or Loss of a loved one |

**FAMILY MENTAL HEALTH HISTORY:** (Check any of the following that are/ were present in your family and who)

\_\_\_\_\_ Depression \_\_\_\_\_

\_\_\_\_\_ Anxiety \_\_\_\_\_

\_\_\_\_\_ Substance Abuse \_\_\_\_\_

\_\_\_\_\_ Suicide Attempt \_\_\_\_\_

\_\_\_\_\_ Sexual Abuse \_\_\_\_\_

\_\_\_\_\_ Eating Disorder \_\_\_\_\_

\_\_\_\_\_ Other Psychiatric/ Emotional Disturbance (explain) \_\_\_\_\_

\_\_\_\_\_

## Adverse Childhood Experience Questionnaire for Adults

Our relationships and experiences- even those in childhood- can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below as this will help you and your provider better understand how to work together to support your health and well-being.

**Instructions:** Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a **checkmark** next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of checkmarks and put the **total number** at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	<input type="checkbox"/>
Did you lose a parent through divorce, abandonment, death, or other reason?	<input type="checkbox"/>
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	<input type="checkbox"/>
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	<input type="checkbox"/>
Did your parents or adults in the home ever hit, punch, beat, or threaten to harm each other?	<input type="checkbox"/>
Did you live with anyone who went to jail or prison?	<input type="checkbox"/>
Did a parent or adult in your home ever swear at you, insult you, or put you down?	<input type="checkbox"/>
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	<input type="checkbox"/>
Did you feel that no one in your family loved you or thought you were special?	<input type="checkbox"/>
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/ penetration)?	<input type="checkbox"/>
<b>Your ACE score is the total number of checked responses</b>	

**Please check the times when you are AVAILABLE for counseling:**

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>8:00 am</b>					
<b>9:00 am</b>					
<b>10:00 am</b>					
<b>11:00 am</b>					
<b>12:00 pm</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					

### **Additional Information before your Session**

Some of our offices are located upstairs, however if you need to meet in an office on the first floor, please inform your therapist before the scheduled Intake appointment so they can make arrangements.

We have three separate waiting areas throughout the building– two located downstairs and one located upstairs. When you arrive, please help yourself to refreshments in the front lobby and have a seat in one of the waiting areas.

Please text your therapist when you arrive or if you might be running late to your appointment. When your therapist is available, they will meet you in the waiting area and escort you to their office.



## INFORMED CONSENT AND HIPAA NOTIFICATION

*Welcome to ReEnvision Counseling! We strive to provide the highest quality of care in a manner that is comfortable and convenient for our clients. Please do not hesitate to ask questions about any of these matters.*

*The following information is provided to assist clients in understanding ReEnvision Counseling's policies & procedures.*

### Appointments

Your first appointment will be the Intake Session, which is reserved with a credit card number once you've been assigned a therapist. After this initial assessment, you and your therapist will schedule additional sessions together. You are able to communicate directly with your therapist rather than going through a receptionist. When you arrive for your session, please help yourself to water, coffee and/or snacks, and your therapist will meet you in the waiting area. Please give your therapist at least 24 hours notice if you must cancel a session. Sometimes illnesses or other emergencies might prevent you from this, which is perfectly understandable. However, that time is reserved specifically for your session, so we must charge you **70% of the session fee if it is not canceled at least 24 hours in advance**. This helps to offset the therapist's lost hour of work but also keeps you from having to pay the full session fee. We will bill the late cancellation fee to the credit card on file, unless you request us to do otherwise.

### Emergencies and Telephone Calls

While you will be seen at a reserved time that fits your individual scheduling demands, there may arise situations when you feel as though you need to speak with your therapist between appointments. If you feel such a need, you may call during normal office hours and your therapist will get back with you as soon as they are able to do so. Emailing is also an excellent option for correspondence with your therapist. If the call will be longer than 5-10 minutes, your therapist might suggest a 25 minute phone session at half the price of a regular session.

**If you are experiencing an emergency, you need to go immediately to the emergency room at the nearest hospital or call the crisis hotline at 855-274-7471.**

### Sessions

During a session, your therapist will do one or more of the following: (a) listen to your concerns and allow you to ventilate your feelings; (b) help you set goals and develop a plan of action to overcome your problems; (c) work with you in reviewing events/ thoughts/ feelings that are hindering you in reaching your goals; and (d) give you reading/ writing assignments designed to help you gain useful insights into your unique situation.

### Risks Involved in Counseling

Counseling involves a degree of risk, usually in the form of feelings that may increase in discomfort for a temporary time. The therapist-client relationship often involves self-disclosure and confrontation, as well as encouragement and support. Sometimes counseling involves recalling unpleasant aspects of your history. Also, any change- even positive change- often disrupts a person's established system. You may meet resistance from other people in your life as a result of changes accomplished through therapy.

### HIPAA Notification for Clients

ReEnvision Counseling is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by informing clients of how they use and disclose Personal Health Information (PHI).

*-What is PHI (Personal Health Information)?*

Name; Address; Telephone Number; E-mail Address; Social Security Number; Medical Information (including initial assessment, progress notes, discharge summaries, treatment plans, etc. Any documentation related to your care)

### ***Client Records of Disclosure***

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of at the individual's home or opting to leave a limited amount of information in a voicemail.

### ***Square Inc.***

If you and your therapist choose to utilize the Customers feature of Square Inc., the ReEnvision Counseling Staff members may have access to a limited amount of your PHI (name, fee, email, last 4 digits of credit card & dates of service).

### ***Social Media***

In order to uphold healthy, ethical boundaries, ReEnvision encourages all staff to reserve their private social media accounts and contacts for personal use only. We recommend that therapists and clients limit their interactions to the therapeutic setting in an effort to protect the confidential nature of the therapeutic relationship. Staff generally should not initiate or accept friend requests except in unusual circumstances such as the situation where an in-person friendship pre-dates the treatment relationship. Even in that case the therapist should consider "unfriending" that person for at least the duration of treatment. This is in the client's best interest and also for the personal health and wellness of the therapist.

### ***Issues of Confidentiality and Privileged Communications***

What you discuss in your established relationship with your therapist is protected by privileged communication laws in the State of Tennessee. This means that no one is allowed to gain access to your personal information (PHI) without your expressed verbal or written consent. All communications are kept private, confidential, and privileged. This is a key aspect of the counseling relationship and one that we work to protect in all situations.

Occasionally, however, for your safety and the safety of others, it becomes necessary for confidentiality to be broken.

The following is a list of serious events for which, by Tennessee State Law, your therapist is required to break confidentiality: (a) If there is imminent danger of serious harm to yourself and/or other people, a therapist may reveal such information to the intended victim and/ or agencies necessary to prevent such harm to yourself or another person; (b) If there is evidence revealed of physical and/or sexual abuse of children, the therapist must report this information to the appropriate authorities; (c) If a court of law issue a legitimate subpoena, ReEnvision Counseling is required by law to provide the information specifically described in the subpoena. (d) for therapists who are under a temporary license and receiving supervision from a licensed professional to collaborate and gain support. (e) for the purpose of pursuing professional excellence, we will occasionally collaborate with our team of professionals in staff meetings, but we always ask a client's permission before using any identifying information.

It is considered "best practice" for a therapist to occasionally consult with supervisors and/ or colleagues to gain perspective, advice, intervention suggestions, or ethical considerations. However, when a client's case is discussed, all identifying information, including names, are excluded from the conversation in order to protect the privacy and integrity of the client.



## **Telehealth Services Agreement**

In the event that we cannot use our facilities for sessions or you are unable to come into the office due to temporary limitations such as medical conditions or distance due to travel, you have the option to participate in Telehealth Services.

“Telehealth” is defined as the use of electronic transmission to provide interactive real-time mental health services remotely, including consultation, assessment, diagnosis, treatment planning, counseling, psychotherapy, coaching, guidance, education, and transfer of medical information with an experienced psychotherapist. This can include both video and audio forms of communication, via the internet or telephone. Telehealth services do not include texting or email. Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychotherapy. Advantages and disadvantages exist in using this method as it offers a way to assist people to meet their mental health needs digitally; however, it may not provide the same level of comfort or seem as complete when talking about personal or private matters.

### ***Emergencies***

Just as with in-person services, if an emergency should occur during a telehealth session, the psychotherapist may consider taking any steps necessary to ensure the safety of the client or of others.

### ***Scheduling***

Just as with an in-person appointment, telehealth sessions are scheduled by prior arrangement.

Scheduling a telehealth appointment involves reserving time specifically for you. Just as with in-person appointments, you are responsible for keeping all telehealth appointments.

We should usually start and end on time. In all telehealth sessions, the therapist will initiate the telehealth session, unless other arrangements have been made. A window will remain open around the starting time of your appointment. Just as with an in-person session, if your psychotherapist doesn't hear from you, s/he will attempt to reach you but will discontinue after several attempts.

Cancellations and unkept appointments are treated just like in-person cancellations and unkept appointments. The psychotherapist is not responsible for the client's ability to participate in the session, including technological limitations.

### ***Confidentiality***

The laws that protect the confidentiality of your medical information in the office also apply to telehealth sessions, including mandatory and permissive exceptions to confidentiality.

The client and psychotherapist both agree to keep the same privacy safeguards as during an in-person session. The environment should be free from unexpected or unauthorized intrusions or disruptions to our communication. There is a risk of being overheard by a third party near you if you do not conduct the session in an enclosed private room, with reasonable sound barriers, and with no one else present or observing.

The client and psychotherapist both agree to not record the telehealth sessions without prior written consent of both parties.

**Consent**

You have the right to opt-in or opt-out of the methods of telehealth communication at any time, without affecting your right to future care or treatment.

It is your responsibility to discuss prior to the telehealth session which medium will be used, how to use it, and any necessary preparation.

**Security**

No electronic transmission system is considered completely safe from intrusion. Interception of communication by third parties remains technically possible. Due to the complexities of electronic media and the internet, risks of telehealth include the potential for the release of private information, including audio and images. So, your psychotherapist cannot fully guarantee the security of telehealth sessions. You are responsible for information security on your computer, laptop, tablet, or smartphone.

**Telephone**

Telehealth can include telephone sessions. When using the telephone, remember to be in a place you feel comfortable speaking about personal and private matters.

**Video Conferencing**

The client is responsible for his/her own hardware and software, audio and video peripherals, and connectivity and bandwidth considerations.

At the time of the telehealth appointment, it is your responsibility to have your electronic device on, video conferencing software launched, and be ready to start the session at the time of the scheduled telehealth appointment.

**Payment**

Just like in-person services, telehealth services are a professional service, and a fee is charged at the same rate as in-person services.

*I have read and understood the information provided above. I have discussed it with my psychotherapist/mediator. All of my questions have been answered to my satisfaction. I hereby request and consent to telehealth services as a part of my treatment. I agree to abide by the terms of this agreement.*

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

## Service Fees

*All payments are due at the time services are rendered unless prior arrangements have been made and agreed upon between ReEnvision Counseling staff and the client.*

### **Intake Appointment**

(50 minute session)

\$150 with Dr. Britt  
\$135 with Marci; Luke  
\$125 with Hannah; Sarah; Matt G  
\$90 with Kim; Morgan; Tori; Matt E; Andy; Sierra  
\$40 with a graduate intern

### **Intake Appointment**

(80 minute session)

\*required for couples & families

\$215 with Dr. Britt  
\$175 with Marci; Luke  
\$165 with Hannah; Sarah; Matt G  
\$125 with Kim; Morgan; Tori; Matt E; Andy; Sierra

### **Individual Therapy**

(50 minute session)

\$125 with Dr. Britt  
\$115 with Marci; Luke  
\$100 with Hannah; Sarah; Matt G  
\$75 with Kim; Morgan; Tori; Matt E; Andy; Sierra  
\$40 with a graduate intern

### **Individual/ Family/ Couples Therapy**

(80 minute session)

\$185 with Dr. Britt  
\$170 with Marci; Luke  
\$150 Hannah; Sarah; Matt G  
\$115 with Kim; Morgan; Tori; Matt E; Andy; Sierra

### **Group Therapy**

To be determined by the facilitator of the group

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#### *Subpoena to Court for Expert Testimony-*

*Non-Refundable Up-Front Retainer fee:*

\$500/ one-time fee

*Court Appearance and Preparation:*

\$250/ hour

*Additional Expenses for Court/ Additional Practice Fees*

TBD

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### **Your Informed Consent to Receiving Care**

We have provided this information in order to inform you of the ReEnvision Counseling policies and procedures. Mental health care offers no guarantees of success, and there are limitations to any form of care offered to a client. Please feel free to discuss any of these matters with your therapist in more detail. By signing below, you acknowledge having read, understood, and agreed to the ReEnvision Counseling policies and procedures. Your signature acknowledges your informed consent to receiving care.\*

\_\_\_\_\_  
*Signature of Client or Parent/ Guardian*

\_\_\_\_\_  
*Date*

The signature below indicates that I have explained the policies and procedures of ReEnvision Counseling to this client and that I have also offered the client a copy of this form.

\_\_\_\_\_  
*Provider's Signature*

\_\_\_\_\_  
*Date*

*\*We reserve the right to update ReEnvision Counseling's policies and procedures as needed with these current rights and responsibilities being applicable, unless you receive a revision when you come in for a future appointment.*

# FEE PAYMENT POLICY AND AUTHORIZATION FORM

Payment for service is expected at the time of the session unless you have made other arrangements with the therapist. **ReEnvision Counseling requires a credit card on file to be used only for missed appointments and late cancellation fees.** In addition, you can *choose* to authorize your therapist to charge you card automatically for sessions that you attend. Because there is an additional banking fee associated with using your credit or debit card, 4% per transaction will be charged when you choose this option.

## Credit/ Debit Card Information

Name on Card \_\_\_\_\_ Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV Number \_\_\_\_\_

Billing ZIP Code \_\_\_\_\_ Email Address \_\_\_\_\_

## Recurring Charge Authorization

The undersigned card member consents and permits ReEnvision Counseling to automatically charge the standard rate for counseling sessions that I attend. I understand there will be an additional (4%) fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service.

\_\_\_\_\_  
*Signature of Client or Parent/ Guardian*

\_\_\_\_\_  
*Date*

## Insurance/ Third Party Billing

Full payment for the session is due at the time of service. We do not file insurance claims, and we are not on insurance panels. However, your therapist will gladly provide the client with a superbill including the information needed to file an insurance claim. Coverage for therapy varies according to a client's plan and the insurance company.

## Authorization

By signing below, I acknowledge that I have read, agreed to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties, including organizations or individuals who are being invoiced for the client's services, for billing purposes and payment of medical benefits to the therapist.

\_\_\_\_\_  
*Signature of Client or Parent/ Guardian*

\_\_\_\_\_  
*Date*



## Statement of Client Rights & Responsibilities

### Statement of Client Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment in accordance with Title VI of the Civil Rights Acts of 1964 and to not be discriminated against. Services are offered to all eligible persons regardless of their race, religion, ethnicity, gender, sexual orientation, age, disability, income level, etc.
- Clients have the right for all their treatment and information to be kept private. Records may only be released by client's permission.
- Clients have the right to easily access timely care in a timely fashion.
- Clients have the right to know about their treatment choices, regardless of cost or coverage by a client's benefit plan.
- Clients have the right to share in developing their plan of care
- Clients have the right to information in a language they can understand.
- Clients have the rights to a clear explanation of their condition and treatment options.
- Clients have the right to ask their provider about their work history and training.
- Clients have the right to know about advocacy and community groups and prevention services.
- Clients have the right to give input on this Statement of Rights and Responsibilities.
- Clients have the right to freely voice concerns or complaints and to have those acted upon.
- Clients have the right to know of their rights and responsibilities in the treatment process.

*\*We reserve the right to change the ReEnvision Counseling Statement of Client Rights and Responsibilities as needed with these current rights and responsibilities being applicable, unless you receive a revision when you come in for a future appointment.*

### Statement of Client Responsibilities

- Clients have the responsibility to treat those giving care to them with dignity and respect.
- Clients have the responsibility to give providers honest information so that providers can deliver the best care possible.
- Clients have the responsibility to ask questions about their care and/or treatment in order to better understand it.
- Clients have the responsibility to follow the treatment plan.
- Clients have the responsibility to tell their provider and primary care doctor about medication changes, including medications given to them by others.
- Clients have the responsibility to keep their appointments. Clients should call their providers as soon as they know they need to cancel visits.
- Clients have the responsibility to let their provider know when the treatment plan isn't working for them.
- Clients have the responsibility to let their provider know about problems with payment.
- Clients have the responsibility to report any abuse or fraud.
- Clients have the responsibility to openly share any concerns they may have about the quality of care they receive.

*\*My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.\**

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Legal Guardian of client (if under the age of 18) Date