Privacy and Rights Acknowledgement

Patient Name:____ Date:__________________

Please read the following polices and initial below:

Initial_____ I have read and understand my **Patient Rights**, stating as a patient of Hope for a Better Tomorrow, I have specific rights that are enumerated in Wisconsin Statutes 51.61 and Wisconsin Administrative Code HHS 94.

Initial_____ I have read and understand the **Cancellation Policy** stating that I can be charged a $50.00 cancellation fee if I cancel my appointment with less than a 24 hour notice. (Unless due to illness or emergency)

Initial_____ I have read and understand my **Limits of Liability Policy** stating therapy services carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of my life are considered risks of therapy sessions.

Initial_____ I have read and understand my **Limits of Confidentiality** stating what I discuss during my therapy session are kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of my legal guardian. The following is a list of exceptions: Duty to Warn and Protect, Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Minors/Guardianship and Insurance Providers and Hope for a Better Tomorrow Clinician Collaboration

Initial_____ I have read and understand the **HIPAA** stating how therapeutic and medical information about you may be used and disclosed, your rights as a patient and ways for you to get additional information on our policies. Our clinic has always been very protective of your personal information. Under new federal regulations (HIPAA Privacy Act), we have adopted additional guidelines to ensure proper use, confidentiality, and disclosure of your health information.

Initial_____ I have read, understand and acknowledge **DHS 75.25(2) - Data Collection:** A service shall have a process for collecting analyzing and reporting a patient's demographics and outcome data. At minimum, the following data shall be recorded at the Admission Session (the first session/intake) and Discharge (Termination): Living Situation, Current Substance Use, Employment Status, Education Level, Arrests in the past 30 days.

By signing below, I am acknowledging that I have read and understand the above polices. Paper or electronic copies can be obtained per request.

____ ____________________

Print Client Name Date

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Client Signature (Client's Parent/Guardian if under 18) Date