Atlanta Psychiatry & Neurology d/b/a Atlanta Behavioral Care

Patient Rights and Responsibilities

Your Right Are:

1. **To be treated with courtesy, dignity and respect.**
2. **To fair treatment regardless of race, religion, gender, ethnicity, age or disability.**
3. **To know about treatment choices, regardless of cost or insurance coverage.**
4. **To share in developing a plan of care.**
5. **To information in a language you understand.**
6. **To have a clear explanation of your condition and treatment options.**
7. **To ask your provider about work history and training.**
8. **To see the healthcare provider of your choice.**
9. **To confidential and private healthcare treatment and confidentiality of your treatment record except under circumstances permitted by Georgia Law.**
10. **To timely care in a timely fashion.**
11. **To know of your rights and responsibilities in the treatment process.**
12. **To name certain preferences in a provider.**

Your Responsibilities Are:

1. **To treat those giving you care with dignity and respect**
2. **To give your treatment providers the information needed in order to care for you.**
3. **To follow the treatment plan and instructions for care that you and your provider have agreed upon.**
4. **To participate, to the degree possible, in understanding your behavioral health problems and in developing with your provider, mutually agreed upon treatment goals.**
5. **To ask questions about your care.**
6. **To inform your provider of medications prescribed to you by others.**

***Limits of Confidentiality*: Georgia law requires exception to confidentiality in the following circumstances: You are a danger to yourself or others: You or a dependent are being abused or neglected: court ordered disclosure.**

***Consultation and Supervision*: In order to provide the best possible services, the doctors and therapists associated by contract with Atlanta Behavioral Care, may engage in supervision and/or consultation. By signing below, I consent to my provider communicating with other healthcare providers at Atlanta Behavioral Care.**

***Medication Prior Authorizations:* Please discuss medication options with your doctor prior to leaving your appointment. If you are prescribed a medication that requires a prior authorization from your insurance company, a $25.00 administration fee will be charged. Requests will be completed within 48 hours of request.**

***What to Expect in Therapy:* What happens in therapy depends on your commitment and participation in your treatment plan. The number of visits will be determined by you and your healthcare provider. The outcome of your treatment cannot be guaranteed. You have the right to stop treatment at any time or request a referral to another provider.**

***Missed Appointments:* You are expected to keep your scheduled appointments. If you fail to keep your appointment without giving a 24-hour notice, you will be charged a $50 broken appointment fee.**

***Assignment and Release:* I, the undersigned, have insurance coverage with your listed insurance carrier. and assign directly to my health care provider at Atlanta Behavioral Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am fully responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.**

Please provide a PHOTO ID and a copy of your insurance card to the office staff. Without Proof of insurance, we require payment in full at the time of your visit.

***Acknowledgment of Our Notices of Privacy Practices:* By signing this I acknowledge I have received or given the opportunity to read or receive a copy of practice's HIPPA Privacy Practices.**

***Consent to treatment:* I have read this form and consent to treatment at Atlanta Behavioral Care. Any questions I have asked concerning this form have been answered to my satisfaction.**

Name of Patient: _____ If Legal Guardian, what is relationship to the Patient? _____

Signature of Patient or Legal Guardian: _____ **Date:** _____