PeaceWay CMS
Counseling & Mediation Services, Inc.

Client Bill Of Rights/Responsibilities

Client Rights : • I have the right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited for me. We will use this plan to help us deal with my problems as quickly and effectively as possible. I have the right to refuse treatment or discontinue treatment. I have a right to be treated with integrity and professionalism.

• I will be treated with respect at all times. I will report any misconduct by my treatment provider to the appropriate state agency. I will report any complaints regarding clerical staff to my therapist/counselor or PCMS owner. My treatment provider will make every effort to meet with me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

• I have the right to privacy and confidentiality. All records and communications about me will be treated with confidentiality in compliance with applicable state and federal laws. These laws may obligate my treatment provider to report suspected abuse, neglect, or domestic violence and those who present a danger to themselves or others.

Client Responsibilities: Scheduled appointments are commitments and I will make every effort to be on time for my appointments. If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my provider at least 24 hours in advance, I understand I may be charged a missed appointment fee.

• I am responsible to pay for services rendered. I am aware my insurance plan typically requires me to pay a co-pay or percentage of my treatment fee at the time services are provided. My insurance plan may also have a deductible plan that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand that I am financially responsible for all co-pays, co-insurance amounts, deductibles and all services not covered by my insurance plan. My provider, the PCMS office staff, and my insurance plan's representative will help me determine what services my plan covers. I am responsible for working with my provider to achieve my treatment goals and will advise my provider of any changes in my physical status, emotional state, or financial status.

I have read or had read to me the ALL of the above list of Rights and Responsibilities. I understand them and agree to them.

Client Name:_____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Social Security Number: _____/ _____/ _____

Signature of Client or Guardian _____

If Guardian what relationship: _____Date: _____/_____/_____

Signature of PCMS Staff reviewing policies _____

Date: _____/_____/_____