Paula Hofmann, MA, LPCC

Client Rights and Responsibilities

Client Rights:

1. You have the right to considerate and respectful treatment and recognition of your personal dignity; the right to impartial access to treatment, regardless of race, religion, sex, age, ethnicity or disability; the right to personal privacy and can expect to be treated with dignity. You will be provided with adequate and human services, regardless of your source of financial support, withing the least restrictive environment available.
2. You have the right to expect that all communications and records pertaining to your treatment will be regarded as confidential, and only those staff members involved in your care or those who have a legal right to the information will have access to your information.
3. You have the right to provide any assistance that you may require in order to particiate in therapy, such as an interpreter, a therapy animal etc. You may reques a first floor room if you are unable to use stairs.
4. You have the right to practice and express religious or cultural values unless doing so will interfer with others' treatment or will harm others in any way.
5. You have a right to a safe environmentm- NO WEAPONS ARE PERMITTED ON PREMISES.
6. You have the right to know any program rules and how they apply to your conduct as a client.
7. You have the right to obtain information about your condition, proposed treatment, the potential benefits and drawbacks of the proposed treatment, problems related to recovery, and your prognosis from your therapist.
8. You have the right to obtain information about alternative treatment and alternative providers.
9. You have the right to report any abuse or neglect, whether you are a victim or an observer.
10. You have the right to be informed of the options available to you when you finish treatment and you will be given a specific plan outlining any recommended continuing care.

Client Responsibilities:

1. You have the responsibility to keep your appointments and to arrive on time. You MUST cancel your appointment 24 hours in advance in order to avoid being charged for the missed appointment.
2. You have the responsibility to provide accurate and complete information about present and past illnesses, hospital stays, medications, advance directives, and other matters pertaining to your health care
3. You have the responsibility to discuss differences of opinion regarding your treatment with your therapist.
4. You have the responsibility to comply with reasonable expectations regarding your conduct while in treatment.
5. You have the responsibility to keep confidential all clinical and personal information communicated to you in individual sessions or in groups by any party receiving or providing treatment.
6. **You have the responsibility to refrain from bringing illicit drugs, alcohol, weapons, or other hazardous material to the practice premises, and to arrive for your session "drug free" and sober.**
7. **You have the responsibility to take any medications prescribed for you exactly as prescribed and to discuss any side effects with your provide**r.
8. You have the responsibility to participate in therapy activities (homework) to the best of your ability.
9. Y**OU ARE RESPONSIBILE FOR READING AND PROVIDING ACCURATE INFORMATION RELATED TO THE CANCELATION POLICY ON THE FOLLOWING PAGE.**

CANCELLATION POLICY:
To avoid a missed appointment charge, appointments must be canceled at least 24 hours in advance.

$50 MISSED APPOINTMENT FEE

Please understand that your appointment time is reserved for you and there are often others who may be waiting to get an appointment.

You will be charged a cancelation fee of $50 if you fail to notify the therapist at least 24 hours in advance. By signing below, I accept this policy, and authorize collection of fees by Paula Hofmann/and/or Delaware DBT Counselors.

1) Credit Card # _____
Visa Master Card American Express Discover Other:_____
Name of Card Holder _____
Expiration Date:_____
CSC/CVV Code:_____Associated Zip code: _____
Signature:_____ Date: _____
(This signature authorizes charging your account for missed appointment.)

Failure to pay the MISSED APPOINTMENT FEES WILL RESULT IN TERMINATION OF SERVICES. You will be referred to your insurance company to obtain a new provider. If you do not have insurance the therapist is NOT OBLIGATED to provide a referral to another provider.

STATEMENT OF UNDERSTANDING AND AGREEGMENT

I have read and understand the cancelation policy and agree that excessive missed appointments may result in termination of services, even when a fee is paid. I agree that my credit card be charged the cancelation fee if any appointment is missed without 24 hour notice. I agree to notify the therapist if the card becomes invalid.

Signed_____ Date: _____
(This signature acknowledges that you have read and understand the policy).

Please be responsible for keeping your appointments and maintaining appropriate reminders.